



King County

1200 King County
Courthouse
516 Third Avenue
Seattle, WA 98104

Meeting Agenda

Health, Housing and Human Services Committee

Councilmembers: Jeanne Kohl-Welles, Chair; Kathy Lambert, Vice Chair; Larry Gossett, Dave Upthegrove

*Staff: Scarlett Aldebot-Green, Lead Staff (206-477-0022)
Sharon Daly, Committee Assistant (206-477-0870)*

1:30 PM

Tuesday, June 7, 2016

Room 1001

Pursuant to K.C.C. 1.24.035 A. and F., this meeting is also noticed as a meeting of the Metropolitan King County Council, whose agenda is limited to the committee business. In this meeting only the rules and procedures applicable to committees apply and not those applicable to full council meetings.

1. Call to Order

2. Roll Call

3. Public Comment

4. Approval of Minutes

To show a PDF of the written materials for an agenda item, click on the agenda item below.

[Minutes of the May 17, 2016 meeting pp. 5-8](#)

Discussion and Possible Action

5. [Proposed Motion No. 2016-0168 pp. 9-14](#)

A MOTION confirming the executive's appointment of Carolyn Heersema, who resides in council district four, to the Seattle/King County advisory council on aging and disability services.

Sponsors: Ms. Kohl-Welles

Miranda Leskinen, Council Staff



*Sign language and communication material in alternate formats can be arranged given sufficient notice (206-1000).
TDD Number 206-1024.
ASSISTIVE LISTENING DEVICES AVAILABLE IN THE COUNCIL CHAMBERS.*



6. [Proposed Motion No. 2016-0224 pp. 15-20](#)

A MOTION confirming the executive's appointment of Marianna Klon, who resides in council district five, to the King County board for developmental disabilities.

Sponsors: Mr. Upthegrove

Scarlett Aldebot-Green, Council Staff

7. [Proposed Motion No. 2016-0265 pp. 21-26](#)

A MOTION confirming the executive's appointment of Julia Sheriden, who resides in council district four, to the King County veterans citizen oversight board, filling an executive at-large position.

Sponsors: Ms. Kohl-Welles

Lauren Mathisen, Council Staff

8. [Proposed Motion No. 2016-0213 pp. 27-108](#)

A MOTION accepting the mental illness and drug dependency eighth annual report, in compliance with Ordinances 15949, 16261 and 16262.

Sponsors: Ms. Kohl-Welles

Wendy Soo Hoo, Council Staff

Briefing

9. [Briefing No. 2016-B0113 pp. 109-122](#)

Winter Shelter Update

Mary Bourguignon, Council Staff

10. [Briefing No. 2016-B0112 pp. 123-176](#)

All Home Strategic Plan Update

Lauren Mathisen, Council Staff

Discussion and Possible Action

11. [Proposed Ordinance No. 2016-0283 pp. 177-195](#)

AN ORDINANCE relating to the structure and duties of a successor to the communities of opportunity interim governance group with respect to the communities of opportunity portion of the best starts for kids levy proceeds; and adding a new section to K.C.C. chapter 2A.300.

Sponsors: Ms. Kohl-Welles and Mr. Dembowski

Katherine Cortes, Council Staff

Contingent upon referral to the Health, Housing and Human Services Committee

Other Business

Adjournment

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King County

1200 King County
Courthouse
516 Third Avenue
Seattle, WA 98104

Meeting Minutes Health, Housing and Human Services Committee

*Councilmembers: Jeanne Kohl-Welles, Chair; Kathy Lambert,
Vice Chair; Larry Gossett, Dave Upthegrove*

*Staff: Scarlett Aldebot-Green, Lead Staff (206-477-0022)
Sharon Daly, Committee Assistant (206-477-0870)*

1:30 PM

Tuesday, May 17, 2016

Room 1001

DRAFT MINUTES

Pursuant to K.C.C. 1.24.035 A. and F., this meeting is also noticed as a meeting of the Metropolitan King County Council, whose agenda is limited to the committee business. In this meeting only the rules and procedures applicable to committees apply and not those applicable to full council meetings.

1. **Call to Order**

Chair Lambert called the meeting to order at 1:34 p.m.

2. **Roll Call**

Present: 3 - Mr. Upthegrove, Ms. Lambert and Mr. Gossett

Excused: 1 - Ms. Kohl-Welles

3. **Public Comment**

There were no speakers.

4. **Approval of Minutes**

*Councilmember Gossett moved approval of the minutes of the May 3, 2016 meeting.
Seeing no objections, the minutes were approved.*

Briefing

5. Briefing No. 2016-B0079

Count Us In

Lauren Mathisen, Council Staff, briefed the committee. Carrie Hennen, All Home, Department of Community and Human Services (DCHS) and Mark Putnam, Project Director-All Home, DCHS, provided comments and answered questions from the members.

This matter was Presented

Discussion and Possible Action

6. Proposed Motion No. 2016-0180

A MOTION accepting the executive's work plan to transfer the administration and management of the homeless management information system to King County as requested by the Motion 14472.

Lauren Mathisen, Council Staff, briefed the committee and answered questions from the members. Josephine Wong, Deputy Director, DCHS, and Mark Putnam, Project Director-All Home, DCHS, also answered questions from the members. Councilmember Upthegrove moved amendment 1. The motion passed unanimously.

This matter was expedited to the May 23, 2016 Council Agenda.

A motion was made by Councilmember Upthegrove that this Motion be Recommended Do Pass Substitute Consent. The motion carried by the following vote:

Yes: 3 - Mr. Upthegrove, Ms. Lambert and Mr. Gossett

Excused: 1 - Ms. Kohl-Welles

Briefing

7. Briefing No. 2016-B0099

Physical and Behavioral Health Integration Design Committee

Susan McLaughlin, Health Integrations Manager, DCHS, briefed the committee via a PowerPoint presentation and answered questions from the members.

This matter was Presented

8. Briefing No. 2016-B0095

Suicide and Suicide Prevention in King County, Washington

Joe Simonetti, MD, MPH, Attending Physician, Harborview Medical Center and Associate Investigator, Harborview Injury Prevention and Research Center, briefed the committee via a PowerPoint presentation and answered questions from the members.

This matter was Presented

Other Business

There was no other business to come before the committee.

Adjournment

The meeting was adjourned at 3:33 p.m.

Approved this _____ day of _____.

Clerk's Signature

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King County

Metropolitan King County Council Health, Housing and Human Services Committee

STAFF REPORT

Agenda Item:	5	Name:	Miranda Leskinen
Proposed No.:	2016-0168	Date:	June 7, 2016

SUBJECT

A motion confirming the Executive's appointment of Carolyn Heersema to the Seattle/King County Advisory Council on Aging and Disability Services.

SUMMARY

The Executive has appointed Carolyn Heersema to the Seattle/King County Advisory Council on Aging and Disability Services for a two-year term expiring December 31, 2017. Proposed Motion 2016-0168 would confirm this appointment.

BACKGROUND

The Seattle/King County Advisory Council on Aging and Disability Services supports the mission of Aging and Disability Services (ADS) and the Area Agency on Aging (AAA) by identifying the needs of older people and adults with disabilities, giving advice on services to meet identified needs and advocating for programs that promote quality of life. King County, the City of Seattle and United Way of King County each appoint nine members to the Advisory Council (for a total of 27 members). Members serve two-year terms.

Carolyn Heersema's application materials note that she has decades of first-hand experience navigating the disability services system as a family member of an individual with disabilities.

ATTACHMENTS

1. Proposed Motion 2016-0168 (Attachments are available upon request)
2. Executive's Transmittal Letter dated February 10, 2016

INVITED

1. Carolyn Heersema, Tlingit Tribe of Alaska Natives representative
2. Pat Lemus, Special Projects Manager, Veterans and Community Services, DCHS

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Signature Report

June 1, 2016

1200 King County Courthouse
516 Third Avenue
Seattle, WA 98104

Motion

Proposed No. 2016-0168.1

Sponsors Kohl-Welles

- 1 A MOTION confirming the executive's appointment of
- 2 Carolyn Heersema, who resides in council district four, to
- 3 the Seattle/King County advisory council on aging and
- 4 disability services.
- 5 BE IT MOVED by the Council of King County:
- 6 The county executive's appointment of Carolyn Heersema, who resides in council
- 7 district four, to the Seattle/King County advisory council on aging and disability services,

8 for a two-year term to expire on December 31, 2017, is hereby confirmed.

9

KING COUNTY COUNCIL
KING COUNTY, WASHINGTON

J. Joseph McDermott, Chair

ATTEST:

Anne Noris, Clerk of the Council

APPROVED this _____ day of _____, _____.

Dow Constantine, County Executive

Attachments: A. Application, B. Financial Disclosure Statement, C. Board Profile, D. Appointment Letter



King County

Dow Constantine

King County Executive
401 Fifth Avenue, Suite 800
Seattle, WA 98104-1818

206-263-9600 Fax 206-296-0194

TTY Relay: 711

www.kingcounty.gov

February 10, 2016

The Honorable Joe McDermott
Chair, King County Council
Room 1200
C O U R T H O U S E

Dear Councilmember McDermott:

Enclosed for consideration and approval by the King County Council is a motion confirming the appointment of Carolyn Heersema, who resides in council district four, to the Seattle/King County Advisory Council on Aging and Disability Services.

The appointment of Ms. Heersema is for a two-year term expiring December 31, 2017. Her application, Code of Ethics Financial Disclosure Statement, current board profile and appointment letter are enclosed for your information. This appointment request supports the King County Strategic Plan goal of public engagement by expanding opportunities to seek input, listen and respond to residents.

If you have any questions about this appointment, please have your staff call Rick Ybarra, liaison for boards & commissions, at 206-263-9651.

Sincerely,

Dow Constantine
King County Executive

Enclosures

King County Councilmembers

ATTN: Carolyn Busch, Chief of Staff

Anne Noris, Clerk of the Council

Carrie S. Cihak, Chief of Policy Development, King County Executive Office

Rick Ybarra, Liaison for Boards & Commissions

Linda C. Wells, Staff Liaison

Carolyn Heersema

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King County

Metropolitan King County Council Health, Housing and Human Services Committee

STAFF REPORT

Agenda Item:	6	Name:	Scarlett Aldebot-Green
Proposed No.:	2016-0224	Date:	June 7, 2016

SUBJECT

A motion confirming the Executive's appointment of Marianna Klon, who resides in council district five, to the King County Board for Developmental Disabilities.

SUMMARY

The Executive has appointed Marianna Klon for the remainder of a three-year term on the King County Board for Developmental Disabilities, expiring September 30, 2018. Proposed Motion 2016-0224 would confirm this appointment.

BACKGROUND

The 15-member Board for Developmental Disabilities is a citizen advisory board that provides oversight of community services for children with developmental delays, adults with developmental disabilities and the families of these individuals. The board develops plans for developmental disability services, advises on funding priorities, and advocates for increases in funding and improvement in services. Board members include family advocates, self-advocates, professionals and interested citizens.

Marianna Klon's application materials note that she has extensive experience with individuals with autism and other developmental disabilities professionally and personally. She indicates she taught students with developmental disabilities in grades 3-9, speaks at related conferences and worked with families and children with developmental disabilities on behavior issues. She holds an MS from Johns Hopkins University, a BA from Marquette University and is WA State Registered Counselor and a Certified Special Education Teacher, K-12.

INVITED

- Marianna Klon, Appointee to Board for Developmental Disabilities
- Holly Woo, Assistant Director, King County Developmental Disabilities Division

ATTACHMENTS:

1. Proposed Motion 2016-0224 (Attachments are available upon request)
2. Executive's Transmittal Letter dated February 26, 2016



KING COUNTY

ATTACHMENT 1

Signature Report

June 1, 2016

1200 King County Courthouse
516 Third Avenue
Seattle, WA 98104

Motion

Proposed No. 2016-0224.1

Sponsors Upthegrove

- 1 A MOTION confirming the executive's appointment of
- 2 Marianna Klon, who resides in council district five, to the
- 3 King County board for developmental disabilities.
- 4 BE IT MOVED by the Council of King County:
- 5 The county executive's appointment of Marianna Klon, who resides in council
- 6 district five, to the King County board for developmental disabilities, for the remainder of

7 a three-year term to expire on September 30, 2018, is hereby confirmed.

8

KING COUNTY COUNCIL
KING COUNTY, WASHINGTON

J. Joseph McDermott, Chair

ATTEST:

Anne Noris, Clerk of the Council

APPROVED this _____ day of _____, _____.

Dow Constantine, County Executive

Attachments: A. Application, B. Financial Disclosure Statement, C. Board Profile, D. Appointment Letter



King County

Dow Constantine

King County Executive
401 Fifth Avenue, Suite 800
Seattle, WA 98104-1818

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www.kingcounty.gov

February 26, 2016

The Honorable Joe McDermott
Chair, King County Council
Room 1200
C O U R T H O U S E

Dear Councilmember McDermott:

Enclosed for consideration and approval by the King County Council is a motion confirming the appointment of Marianna Klon, who resides in council district five, to the King County board for developmental disabilities.

The appointment of Ms. Klon is for the remainder of a three-year term expiring September 30, 2018. Her application, Code of Ethics Financial Disclosure Statement, current board profile and appointment letter are enclosed for your information. This appointment request supports the King County Strategic Plan goal of public engagement by expanding opportunities to seek input, listen and respond to residents.

If you have any questions about this appointment, please have your staff call Rick Ybarra, liaison for boards & commissions, at 206-263-9651.

Sincerely,

Dow Constantine
King County Executive

Enclosures

King County Councilmembers

ATTN: Carolyn Busch, Chief of Staff

Anne Noris, Clerk of the Council

Carrie S. Cihak, Chief of Policy Development, King County Executive Office

Rick Ybarra, Liaison for Boards & Commissions

Michaëlle Monday, Staff Liaison

Marianna Klon

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King County

Metropolitan King County Council Health, Housing and Human Services Committee

STAFF REPORT

Agenda Item:	7	Name:	Lauren Mathisen
Proposed No.:	2016-0265	Date:	June 7, 2016

SUBJECT

A MOTION confirming the executive's appointment of Julia Sheriden, who resides in council district four, to the King County Veterans Citizen Oversight Board, as an executive at-large representative.

SUMMARY

The executive has forwarded for council consideration and approval the appointment of Julia Sheriden (Proposed Motion 2016-0265) to the King County Veterans Citizen Oversight Board, as an executive at-large representative, to a three-year term expiring December 31, 2018.

BACKGROUND

The King County Veterans Citizen Oversight Board (VCOB) monitors and reviews the expenditure of the veteran portion of the Veterans and Human Services Levy (VHSL) proceeds in accordance with the Service Improvement Plan (SIP) developed and approved by the King County Executive and the Metropolitan King County Council to guide levy investments.¹

The VCOB is a 12-member board comprised of King County residents with a diverse, balanced representation of people from different groups, organizations, and experiences. Members may not be elected or appointed officials of any unit of government. Nine of the members are chosen to represent county council districts and the remaining three serve at-large and are appointed by the King County Executive; these are typically recommended by the Veterans Program Advisory Board. Board members are appointed for three-year terms and requirements are described in King County Ordinance 15279 (September 2005), the levy implementation ordinance, and Ordinance 15406 (April 2006). Broadly, board duties include:

- Becoming familiar with the Service Improvement Plan
- Reviewing funding proposals
- Assuring that funding plans follow guidelines in the Service Improvement Plan

¹ The current SIP, required under the ordinance 15279, provides guidance with regards to VHSL-funded activities from 2012 through 2017.

- Providing recommendations about the expenditure of the veteran portion of levy proceeds
- Providing recommendations and reports to the County Council as required

Julia Sheriden was appointed by the Executive to serve as an at-large representative on the VCOB. Ms. Sheriden retired in 2002 from the United States National Park Service, where she was an information technology specialist. She served in the United States Marine Corps from 1978 until she was injured in the line of duty and received a medical discharge in 1981. She is the founder and president of the 501(c)3 nonprofit Outreach and Resource Services for Women Veterans (OARS) and volunteered with Disabled American Veterans Washington Chapter 13 for eleven years, including as commander. She describes herself as a lay expert on veterans issues, particularly those related to women veterans, informed by experiences navigating complex veterans systems in support of her own needs as well as thirty years of experience working with veterans as a volunteer.

ATTACHMENTS

1. Proposed Motion 2016-0265 (Attachments available upon request)
2. Executive's Transmittal Letter dated February 26, 2016

INVITED

1. Julia Sheridan, President and Founder of Outreach and Resource Services for Women Veterans (OARS)
2. Marcy Kubbs, Veterans and Human Services Levy Coordinator



KING COUNTY

ATTACHMENT 1

Signature Report

June 6, 2016

1200 King County Courthouse
516 Third Avenue
Seattle, WA 98104

Motion

Proposed No. 2016-0265.1

Sponsors Kohl-Welles

- 1 A MOTION confirming the executive's appointment of
- 2 Julia Sheriden, who resides in council district four, to the
- 3 King County veterans citizen oversight board, filling an
- 4 executive at-large position.
- 5 BE IT MOVED by the Council of King County:
- 6 The county executive's appointment of Julia Sheriden, who resides in council
- 7 district four, to the King County veterans citizen oversight board, filling an executive

8 at-large position, for a three-year term to expire on December 31, 2018, is hereby
9 confirmed.

10

KING COUNTY COUNCIL
KING COUNTY, WASHINGTON

J. Joseph McDermott, Chair

ATTEST:

Anne Noris, Clerk of the Council

APPROVED this ____ day of _____, ____.

Dow Constantine, County Executive

Attachments: A. Application, B. Financial Disclosure Statement, C. Board Profile, D. Appointment Letter



King County

Dow Constantine

King County Executive

401 Fifth Avenue, Suite 800
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February 26, 2016

The Honorable Joe McDermott
Chair, King County Council
Room 1200
C O U R T H O U S E

Dear Councilmember McDermott:

Enclosed for consideration and approval by the King County Council is a motion confirming the appointment of Julia Sheriden, who resides in council district four, to the King County Veterans Citizen Oversight Board, filling an executive at-large position.

The appointment of Ms. Sheriden is for a three-year term expiring December 31, 2018. Her application, Code of Ethics Financial Disclosure Statement, current board profile and appointment letter are enclosed for your information. This appointment request supports the King County Strategic Plan goal of public engagement by expanding opportunities to seek input, listen and respond to residents.

If you have any questions about this appointment, please have your staff call Rick Ybarra, liaison for boards & commissions, at 206-263-9651.

Sincerely,

Dow Constantine
King County Executive

Enclosures

King County Councilmembers

ATTN: Carolyn Busch, Chief of Staff

Anne Noris, Clerk of the Council

Carrie S. Cihak, Chief of Policy Development, King County Executive Office

Rick Ybarra, Liaison for Boards & Commissions

Marcy Kubbs / Laird Redway, Staff Liaison

Julia Sheriden

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King County

Metropolitan King County Council Health, Housing and Human Services Committee

STAFF REPORT

Agenda Item:	8	Name:	Wendy Soo Hoo
Proposed No.:	2016-0213	Date:	June 7, 2016

SUBJECT

A MOTION accepting the mental illness and drug dependency eighth annual report, in compliance with Ordinances 15949, 16261 and 16262.

SUMMARY

The eighth annual Mental Illness and Drug Dependency (MIDD) report covers the time period from October 1, 2014 to September 30, 2015. Ordinance 15949 requires the MIDD Annual Report. This report gives an overview of the programs and services supported by the one-tenth of one percent sales tax revenues approved by the King County Council. The report also briefly discusses ongoing work to support the potential renewal of the MIDD, which expires on January 1, 2017.

BACKGROUND

State Authorizes Sales Tax:

In 2005 the Washington State Legislature authorized counties to implement a one-tenth of one percent sales and use that tax to support new and expanded chemical dependency or mental health treatment programs and services and for the operation of new or expanded therapeutic court programs and services.

King County Authorizes Sales Tax:

In 2007, the King County Council adopted Ordinance 15949 authorizing the levy and collection of an additional sales and use tax of one-tenth of one percent for the delivery of mental health and chemical dependency services and therapeutic courts. This tax is referred to as the Mental Illness and Drug Dependency sales tax (MIDD).

King County Adopts MIDD Policy Goals, Establishes the MIDD Oversight Committee, and Adopts the MIDD Implementation and the MIDD Oversight Plans:

Ordinance 15949 also established a policy framework for measuring the effectiveness of the public's investment in MIDD programs, requiring the King County Executive to submit oversight, implementation and evaluation plans for the programs funded with the tax

revenue. The ordinance set forth five policy goals for the programs supported with MIDD funds, as shown in the table below.

Policy Goal 1: A reduction in the number of mentally ill and chemically dependent people using costly interventions such as jail, emergency rooms, and hospitals.

Policy Goal 2: A reduction in the number of people who recycle through the jail, returning repeatedly as a result of their mental illness or chemical dependency.

Policy Goal 3: A reduction of the incidence and severity of chemical dependency and mental and emotional disorders in youth and adults.

Policy Goal 4: Diversion of mentally ill and chemically dependent youth and adults from initial or further justice system involvement.

Policy Goal 5: Explicit linkage with, and furthering the work of, other Council directed efforts including, the Adult and Juvenile Justice Operational Master plans, the Plan to End Homelessness, the Veterans and Human Services Levy Service Improvement Plan and the King County Mental Health Recovery Plan (now the Recovery and Resiliency - Oriented Behavioral Health Services Plan).

Subsequent ordinances established the MIDD Oversight Committee (April 2008)¹ and the MIDD Implementation Plan and MIDD Evaluation Plan (October 2008).² The Oversight Committee reviews and comments on quarterly, annual and evaluation reports as required, and also reviews and comments on emerging and evolving priorities for the use of the MIDD sales tax revenue. The Co-Chairs of the MIDD Oversight Committee during the reporting period were Merrill Cousin, Executive Director, King County Coalition Against Domestic Violence, and Johanna Bender, Judge, King County Superior Court.

Supplantation:

The initial 2005 Washington State legislation that authorized counties to implement the sales and use tax did not permit revenues to be used to supplant other existing funding. The statute has since been revised three times.

The statute was revised in 2008 to allow MIDD funds to be used for housing that is part of a coordinated chemical dependency or mental health treatment program, and in 2009 to allow MIDD revenue to supplant funds for existing mental health, chemical dependency, and therapeutic court services and programs. In 2011, the statute was revised to increase the percentage of revenue that could be used to supplant funds for existing programs—50

¹ The MIDD Oversight Committee was established in Ordinance 16077 and is an advisory body to the King County executive and the council. The purpose of the Oversight Committee is to ensure that the implementation and evaluation of the strategies and programs funded by the tax revenue are transparent, accountable and collaborative.

² In October 2008, the Council adopted the MIDD Implementation Plan and the MIDD Evaluation Plan via Ordinance 16261 and Ordinance 16262.

percent in 2012, 40 percent in 2013, 30 percent in 2014, 20 percent in 2015, and 10 percent in 2016. The Legislature further amended the statute to allow for revenue to be used to support therapeutic courts' judicial officers and support staff without these counting as supplanted funds.

MIDD Key Facts:

- The tax became effective on April 1, 2008. It expires on January 1, 2017. The Washington State statute does not establish an expiration date for the legislation authorizing this tax; the expiration date was established by the Council via Ordinance 15949.
- Projections indicate that the tax will generate \$119 million in the 2015/2016 biennium.³
- An estimated \$11.4 million in services currently supported by MIDD will have to shift to be supported by the General Fund in 2017/2018 under the supplantation statute – this represents approximately 23 percent of the projected \$50 million General Fund shortfall.

Ongoing Work to Review MIDD and Support Potential Renewal of MIDD:

As described in the eighth MIDD annual report, the King County Council passed Ordinance 17998 in March 2015, requiring the Department of Community and Human Services (DCHS) to:

- Review and assess the performance of MIDD since the tax became effective in 2008 and
- Develop an updated service improvement plan (SIP) to guide investments if the King County Council authorizes renewal of the MIDD.

The retrospective review is due in June 2016 and the SIP is anticipated to be transmitted in late August.

ANALYSIS

The services and programs funded by the MIDD Plan are evaluated by staff in King County's Department of Community and Human Services (DCHS) based on data submitted by providers. The attached Mental Illness and Drug Dependency Eighth Annual Report is in compliance with the requirements under Ordinances 15949, 16261, and 16262.

Below are highlights of the eighth annual report:

- **Number of clients served:** According to the report, MIDD-supported programs served 35,902 unduplicated individual clients during the reporting period. An additional 21,730 individuals were counted in large group settings, though no personal identifiers were collected to unduplicate them. Of the unduplicated

³ Revenue estimate reflects the March 2016 Office of Economic and Financial Analysis March sales tax forecast.

individuals, 49 percent were male, 49 percent were female, and two percent were categorized as “other/unknown.” The MIDD client population was made up by individuals identifying their primary race as follows: Caucasian/White (52 percent), other/unknown (16 percent), African-American/Black (13 percent), Asian/Pacific Islander (12 percent), multiple races (5 percent), and Native American (2 percent).

- **Spending**: \$57.9 million of the \$59.5 million budgeted was spent on MIDD strategies and supplantation during the 2015 calendar year. The projected fund balance is \$9.2 million.
- **Individuals Served Based on Geography**: \$20 million was spent to help individuals reporting Seattle zip codes, \$10 million for those with south county zip codes, and a combined \$8 million for people reporting zip codes associated with the east and north regions.
- **Overall Performance**: According to the report, most strategies achieved positive target success ratings by meeting 85 percent or more of their performance measurement targets (e.g., a strategy is considered to achieve positive target success if it had a goal of serving 100 clients and served at least 85).
- **Reduction in Jail Utilization**: For individuals in the first year of receiving MIDD supported services, 16 of 20 strategies or sub-strategies intended to reduce adult jail utilization achieved reductions of at least 10 percent. Of the 20 strategies, 17 strategies were eligible for analysis of individuals in their fourth year of receiving services and nine of these achieved booking reductions of more than 55 percent.
- **Reductions in Harborview Medical Center’s Emergency Department Admissions**: Ten of 14 strategies were expected to reduce admissions to Harborview Medical Center’s emergency department. Ten of these achieved reductions of 20 percent or greater for individuals in the second year of services.

INVITED:

- Kelli Carroll, Strategic Policy Advisor, Department of Community and Human Services

ATTACHMENTS:

1. Proposed Motion 2016-0213 with attachments
2. Transmittal Letter



Signature Report

May 2, 2016

1200 King County Courthouse
516 Third Avenue
Seattle, WA 98104

Motion

Proposed No. 2016-0213.1

Sponsors Kohl-Welles

1 A MOTION accepting the mental illness and drug
2 dependency eighth annual report, in compliance with
3 Ordinances 15949, 16261 and 16262.

4 WHEREAS, in 2005, the state Legislature authorized counties to implement a
5 one-tenth of one percent sales and use tax to support new or expanded chemical
6 dependency or mental health treatment programs and services and for the operation of
7 new or expanded therapeutic court programs and services, and

8 WHEREAS, in November 2007, Ordinance 15949 authorized the levy collection
9 of and legislative policies for the expenditure of revenues from an additional sales and
10 use tax of one-tenth of one percent for the delivery of mental health and chemical
11 dependency services and therapeutic courts, and

12 WHEREAS, the ordinance defined the following five policy goals for programs
13 supported through sales tax funds:

14 1. A reduction of the number of people who are mentally ill and chemically
15 dependent using costly interventions like jail, emergency rooms and hospitals;

16 2. A reduction of the number of people who recycle through the jail, returning
17 repeatedly as a result of their mental illness or chemical dependency;

18 3. A reduction of the incidence and severity of chemical dependency and mental
19 and emotional disorders in youth and adults;

20 4. Diversion of mentally ill and chemically dependent youth and adults from
21 initial or further justice system involvement; and

22 5. Explicit linkage with, and furthering the work of, other council-directed efforts
23 including the adult and juvenile justice operational master plans, the ten year plan to end
24 homelessness, the veterans and human services levy service improvement plan and the
25 county mental health recovery plan, and

26 WHEREAS, the ordinance established a policy framework for measuring the
27 public's investment, requiring the King County executive to submit oversight,
28 implementation and evaluation plans for the programs funded with tax revenue, and

29 WHEREAS, each of those plans was developed in collaboration with the mental
30 illness and drug dependency oversight committee and each was approved by the council
31 in 2008, and

32 WHEREAS, the mental illness and drug dependency plans established a
33 comprehensive framework to ensure that the strategies and programs funded through the
34 one-tenth of one percent sales tax are transparent, accountable, collaborative and
35 effective, and

36 WHEREAS, Ordinance 15949, as amended, set forth the required elements of the
37 mental illness and drug dependency annual report, and

38 WHEREAS, the mental illness and drug dependency annual report, which is
39 Attachment A to this motion, has been reviewed and approved by the mental illness and
40 drug dependency oversight committee;

41 NOW, THEREFORE, BE IT MOVED by the Council of King County:
42 The mental illness and drug dependency eighth annual report is hereby accepted.
43

KING COUNTY COUNCIL
KING COUNTY, WASHINGTON

J. Joseph McDermott, Chair

ATTEST:

Anne Noris, Clerk of the Council

APPROVED this ____ day of _____, ____.

Dow Constantine, County Executive

Attachments: A. Mental Illness and Drug Dependency Eighth Annual Report

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Mental Illness and Drug Dependency

Eighth Annual Report



**Implementation and Evaluation Summary for Year Seven
October 1, 2014—September 30, 2015**



King County

Mental Illness and Drug Dependency Oversight Committee

February 2016

King County Department of Community and Human Services

401 Fifth Avenue, Suite 500
Seattle, WA 98104

Phone: 206-263-9100

Adrienne Quinn - Director

Behavioral Health and Recovery Division

Jim Vollendroff - Division Director

Brad Finegood - Assistant Division Director and Acting RSN Administrator
Prevention and Treatment Coordinator

Kelli Carroll - Strategic Advisor

Andrea LaFazia-Geraghty - Mental Illness and Drug Dependency (MIDD)
and Prevention Section Manager

Laurie Sylla - Systems Performance Evaluation Coordinator

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Eighth Annual Report October 1, 2014–September 30, 2015

Cover photo depicts the Community Conversation event in Renton, Washington
(See the MIDD Review and Renewal Update on Page 1)
Cover photo by Sherry Hamilton

Report analysis and design by Lisa Kimmerly
Data support from Marla Hoffman and Genevieve Rowe
Provider features and client success stories by Kimberly Cisson

**For further information on
the current status of MIDD activities,
please see the MIDD website at:**

www.kingcounty.gov/healthservices/MHSA/MIDDPlan

Alternate formats available
Call 206-263-8663
or TTY Relay 711

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What is MIDD?

King County's Mental Illness and Drug Dependency (MIDD) is a countywide sales tax generating approximately \$53 million per year for mental health and substance abuse services and programs. As required by state legislation (Revised Code of Washington 82.14.460), revenue raised under the MIDD is to be used for certain mental health and substance use disorder services, including King County's therapeutic courts. King County's MIDD was passed by the Metropolitan King County Council in 2007, and MIDD-funded services began in 2008. Unless renewed by the Council, the MIDD will expire on December 31, 2016. King County is one of 23 counties in Washington state that has authorized the tax revenue.

MIDD Review and Renewal Update

In March 2015 the King County Council passed Ordinance 17998, calling for a comprehensive historical review and assessment of MIDD I (due in June 2016) and a MIDD II service improvement plan (SIP) (due in December 2016). In order to inform the Council's 2017-2018 biennial budget deliberations that will occur in fall of 2016, the MIDD II SIP will be transmitted concurrently with the King County Executive's 2017-2018 Proposed Budget. Legislation to renew the sales tax is slated to be transmitted to the Council in June.

Executive staff and the MIDD Oversight Committee have undertaken a number of MIDD review and renewal planning activities. Please note that some of the items below occurred outside of the reporting period (ending September 2015). Highlights of the MIDD II renewal activities through February 2016 include:

- Creation of a website hub for information and resources related to the MIDD review and renewal process
- Development of MIDD Oversight Committee Values and Guiding Principles for renewal activities
- Open call for MIDD II new concepts between September 15 and October 31, 2015 that generated over 140 suggestions for potential use of MIDD II funding
- Development and analysis of new concepts and existing MIDD strategies
- Creation of a review process for new concepts and existing MIDD strategies that includes community participation at multiple points
- 20 community engagement meetings and focus groups, including five large, regional community conversations, with over 600 community members involved
- Transmittal of a MIDD renewal progress report to the Council in November 2015
- Report on MIDD renewal activities at each MIDD Oversight Committee meeting.



Photos by Sherry Hamilton



MIDD Reporting Requirements

This is the Eighth Annual MIDD Report, covering the time period of October 1, 2014, through September 30, 2015.

Through MIDD legislation (Ordinances 15949 and 16262), King County policymakers established the requirement to report on MIDD's services and programs. Legislation set forth MIDD's Policy Goals, along with key components that are to be included in every MIDD annual report, including:

- a) A summary of semi-annual report data*
- b) Updated performance measure targets for the following year of the programs*
- c) Recommendations on program and/or process changes to funded programs based on the measurement and evaluation data*
- d) Recommended revisions to the evaluation plan and processes*
- e) Recommended performance measures and performance measurement targets for each mental illness and drug dependency strategy, as well as any new strategies that are established.*

Legislation also adopted the schedule and timeframe of the annual reports.

The five adopted MIDD Policy Goals* are:

1. Reduce the number of people with mental illness and substance use disorders using costly interventions, such as jail, emergency rooms and hospitals.
2. Reduce the number of people who recycle through the jail, returning repeatedly as a result of their mental illness or chemical dependency.
3. Reduce the incidence and severity of chemical dependency and mental and emotional disorders in youth and adults.
4. Divert youth and adults with mental illness and substance use disorders from initial or further justice system involvement.
5. Link with and further the work of other Council-directed efforts, including the Adult and Juvenile Justice Operational Master Plans, the Ten-Year Plan to End Homelessness, the Veterans and Human Services Levy Service Improvement Plan and the King County Mental Health Recovery Plan.

** Edited from Ordinance 15949*

As required, the annual MIDD reports are reviewed by the MIDD Oversight Committee and transmitted by the County Executive to the Council for acknowledgement by motion. MIDD progress reports are also compiled, reviewed and transmitted for the Council's review.

In this Eighth Annual MIDD Report, comprehensive performance measurement statistics and a summary of key outcomes results over the life of the MIDD are provided. Each reader is encouraged to study the information presented when drawing conclusions about the effectiveness of MIDD programming. Please note that steps for assessing strategy effectiveness are outlined on Page 8 to guide the process of critically evaluating each MIDD strategy.

MIDD Annual Report Purpose, Processes, Timelines and Terms

The purpose of the MIDD annual report is to provide transparent accountability to the King County Council, King County taxpayers and interested stakeholders on how MIDD sales tax funds are used, changes in how strategies are implemented, observed results achieved by people who receive MIDD services, and progress toward achieving MIDD policy goals.

Data submitted to the MIDD Evaluation Team by more than 100 providers, subcontractors and partners is currently stored in three major databases: 1) the statewide TARGET substance use treatment database (DB), 2) King County's mental health system, and 3) a separate MIDD database. Information is typically due, in accordance with contract requirements, on a monthly or quarterly basis. In some cases, providers query their own data systems and computers automatically process the data, while in other cases, spreadsheets are completed by hand and submitted via secure file transfer protocols, or uploaded to secure servers. When the data submission process is more manual than automated, significant staff time is generally required to clean, process and compile the information received. In order to produce demographic and outcomes findings, clients must be unduplicated and cross-referenced with their system-use results provided by all King County and municipal jails and select hospital partners. The timeline for data preparation and analysis is as follows:

Last Evaluation Data Due (through September 30)	Data Cleaned and Loaded in DB	Queries Run and Results Unduplicated	Outcomes Data Ready and Analysis Begins	Report Review Begins
Mid-November	Mid-December	Early January	Mid-January	Early February

Longitudinal Evaluation of Outcomes

For most strategies, client outcomes are studied using a longitudinal evaluation methodology. This method involves collecting data for the same group of individuals over time and then making comparisons between various time periods. In this report, outcomes are studied for up to five years after a person's MIDD start date. The following definitions for study time periods are used throughout the report:

- **Pre:** The one-year period leading up to a person's first MIDD start date within each relevant strategy.
- **First through Fifth Post:** Each subsequent one-year span following a person's start date.

Cohorts of clients become eligible for inclusion in various outcomes samples through the passage of time (time eligible) and their use of any given system, such as jails and hospitals, in each time period (use eligible). Tables and graphs on Pages 58 to 69 show MIDD strategies aligned with relevant outcome types, eligible sample sizes, the total number of bookings, admissions, or days in each time period, and the percent change, which is calculated by subtracting the Pre measure from each Post measure and dividing by the Pre measure. On some pages, data appears in strategy order, while on others it has been sorted to rank-order the strategies by various results.

Services may be delivered in a single encounter (service visit), or they may be ongoing for an extended time, such as months or even years. Service "dose" varies widely both within and between strategies. Analysts look for patterns in the data that can suggest relationships between measured variables without implying causation, as other factors not being measured could also be contributing to any observed results.

Definitions of Key Terms

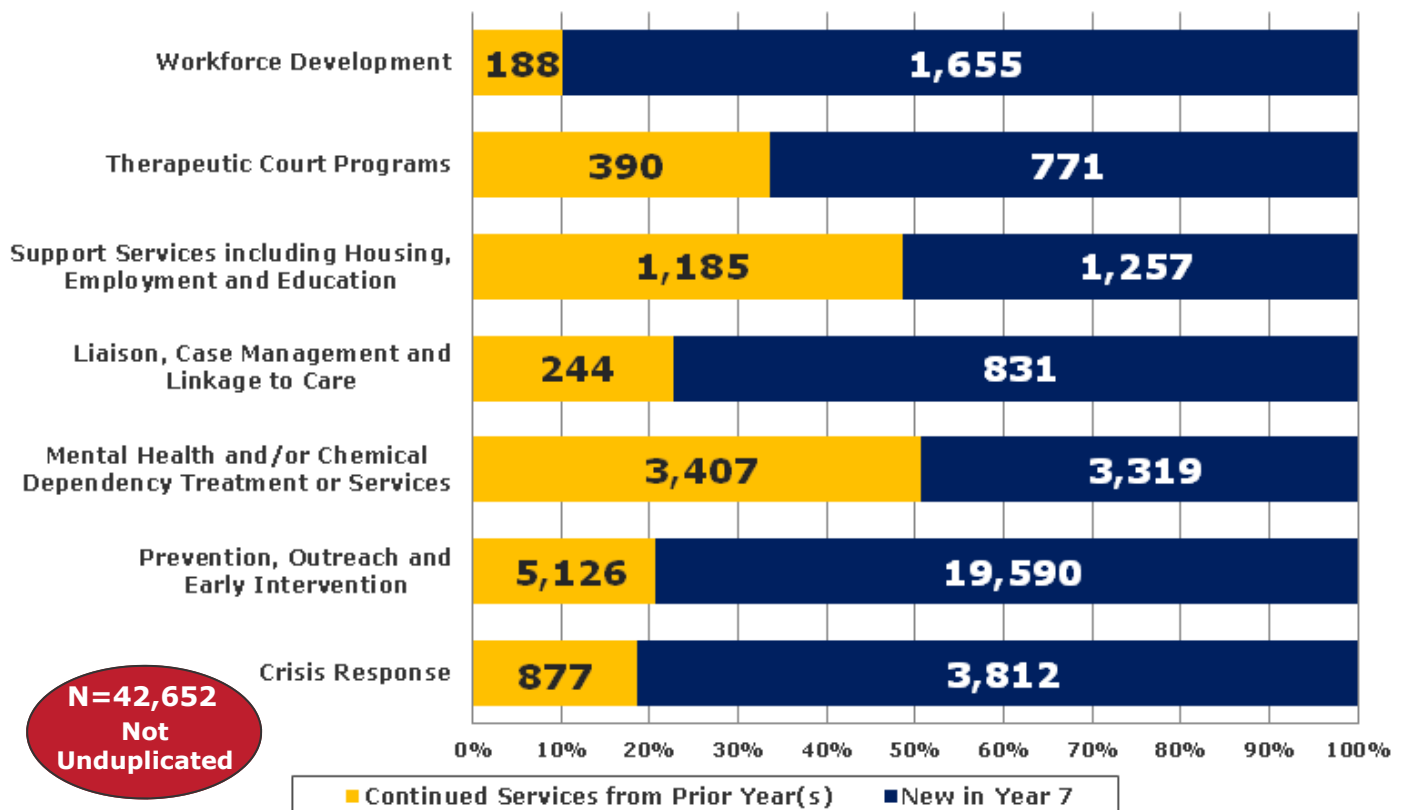
Strategy	A program or series of programs that provide specific services or employ specific approaches to achieve intended goals.
Target	Quantifiable outputs expected of an entity implementing a strategy; How many people will be served and/or how many services will be provided.
Revised target	Changed expected output goals, usually permanent, due to new or better information.
Adjusted target	Changed expected output goals, usually temporary, due to changes in funding, staffing, policy or approach.
FTE	Full-time equivalent staffing. This is used to contextualize several MIDD targets.
Performance Measurement	The actual number of clients seen or services delivered; also represented as a percentage of the original, revised or adjusted target.
Targeted reductions	The amount of change expected in system use (jail, emergency department, psychiatric hospital) over time by individuals being served by particular strategies.
Outcomes	Measurable or observable end results or effects; something that happens as a result of an activity or process.

Annual Report Highlights

The following are key highlights from the annual report period of October 1, 2014, through September 30, 2015. Page numbers are shown where details are discussed:

- The MIDD Oversight Committee members contributed 446 cumulative hours in meetings and subcommittee activities. Non-members contributed an additional 184 hours. (Page 7)
- Individual-level information was available for at least 35,902 unduplicated clients served during the reporting period. An additional 21,730 people were counted in large group settings, but no personal identifiers were collected to unduplicate them. (Page 46)
- More people reporting zip codes from the south region of the county (35%) utilized services, compared to people with Seattle zip codes (33%), for the first time in over four years. (Page 46)
- Data from 2014 showed that \$20 million was spent to help individuals reporting Seattle zip codes, \$10 million for those with south county zip codes, and a combined \$8 million for people reporting zip codes associated with the east and north regions. (Page 48)
- \$57.9 million of the \$59.5 million budgeted was spent on MIDD strategies and supplantation during the 2015 calendar year. The projected fund balance is \$9.2 million. (Pages 49-51)
- Most strategies achieved positive target success ratings by meeting 85 percent or more of their performance measurement targets. For example, if a strategy was expected to serve 100 clients and they saw at least 86, they earned a green arrow. (Pages 54–56)
- Twenty strategies or sub-strategies were expected to reduce jail bookings and days for individuals served. It was more common for clients to reduce bookings than to reduce days (Pages 59-65)
- Fourteen strategies or sub-strategies were expected to reduce admissions to Harborview Medical Center's emergency department. Ten of these achieved reductions of 20 percent or greater in the second year after the start of MIDD services, which was a favorable outcome. (Page 66)
- Ten strategies were expected to reduce psychiatric hospitalizations for clients served. At least nine strategies achieved targeted reductions during at least one outcomes analysis period. (Pages 68-69)

Total Number of Individuals Served by Type of Service



Oversight Committee Membership Roster

Johanna Bender, Judge, King County District Court
(Co-Chair)

Representing: District Court

Merril Cousin, Executive Director, King County
Coalition Against Domestic Violence (Co-Chair)

Representing: Domestic violence prevention services

Dave Asher, Kirkland City Council

Councilmember, City of Kirkland

Representing: Sound Cities Association

Rhonda Berry, Chief of Operations

Representing: King County Executive

Jeanette Blankenship, Fiscal and Policy Analyst

Representing: City of Seattle

Susan Craighead, Presiding Judge, King County
Superior Court

Representing: Superior Court

Claudia D'Allegri, Vice President of Behavioral Health,
SeaMar Community Health Centers

Representing: Community Health Council

Nancy Dow, Member, King County Mental Health
Advisory Board

Representing: Mental Health Advisory Board

Lea Ennis, Director, Juvenile Court, King County
Superior Court

Representing: King County Systems Integration
Initiative

Ashley Fontaine, Director, National Alliance on Mental
Illness (NAMI)

Representing: NAMI in King County

Pat Godfrey, Member, King County Alcoholism and
Substance Abuse Administrative Board

Representing: King County Alcoholism and
Substance Abuse Administrative Board

Shirley Havenga, Chief Executive Officer,
Community Psychiatric Clinic

Representing: Provider of mental health and
chemical dependency services in King County

Patty Hayes, Director, Public Health—Seattle & King
County

Representing: Public Health

William Hayes, Director, King County Department of
Adult and Juvenile Detention

Representing: Adult and Juvenile Detention

Mike Heinisch, Executive Director, Kent Youth and
Family Services

Representing: Provider of youth mental health and
chemical dependency services in King County

Darcy Jaffe, Chief Nurse Officer and Senior Associate
Administrator, Harborview Medical Center

Representing: Harborview Medical Center

Norman Johnson, Executive Director, Therapeutic
Health Services

Representing: Provider of culturally specific chemical
dependency services in King County

Ann McGettigan, Executive Director, Seattle
Counseling Service (Co-Chair)

Representing: Provider of culturally specific mental
health services in King County

Barbara Miner, Director, King County Department of
Judicial Administration

Representing: Judicial Administration

Mark Putnam, Director, Committee to End
Homelessness in King County

Representing: Committee to End Homelessness

Adrienne Quinn, Director, King County Department of
Community and Human Services (DCHS)

Representing: King County DCHS

Lynne Robinson, Bellevue City Council
Councilmember, City of Bellevue

Representing: City of Bellevue

Dan Satterberg, King County Prosecuting Attorney

Representing: Prosecuting Attorney's Office

Mary Ellen Stone, Director, King County Sexual
Assault Resource Center

Representing: Provider of sexual assault victim
services in King County

Dave Upthegrove, Councilmember, Metropolitan King
County Council

Representing: King County Council

John Urquhart, Sheriff, King County Sheriff's Office

Representing: Sheriff's Office

Chelene Whiteaker, Director, Advocacy and Policy,
Washington State Hospital Association

Representing: Washington State Hospital
Association/King County Hospitals

Lorinda Youngcourt, Director, King County
Department of Public Defense

Representing: Public Defense

Oversight Committee Staff:

Bryan Baird, Mental Health, Chemical Abuse and
Dependency Services Division (MHCADSD)

Kelli Carroll, Strategic Advisor, MHCADSD

Andrea LaFazia-Geraghty, MHCADSD

As of 9/30/2015

Letter from Oversight Committee Co-Chairs

Dear Reader:

The Eighth Annual MIDD Report before you comprises the Mental Illness and Drug Dependency (MIDD) Implementation and Evaluation Summary for Year Seven (October 1, 2014 – September 30, 2015). As noted, this report includes comprehensive performance measurement data and a summary of key outcomes results over the life of the MIDD. We encourage you to review the data provided as you consider the effectiveness of MIDD programs and services. Steps to help readers review strategies for effectiveness are included on Page 8.

New in this report is an overview of the MIDD reporting processes, timelines, and terms, found on Page 3. This is included to give readers, especially those who are new to MIDD, a more comprehensive understanding of MIDD reporting and the complexity of MIDD data collection and preparation. We also include a glossary of MIDD terms used in this report.

Individual MIDD strategy summary pages include a strategy overview, the particular MIDD policy goals addressed by the strategy, strategy performance measurement data and a summary of key findings. Where performance measurement information is provided, additional information may be included to contextualize targets and changes to targets.

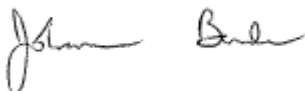
Selected program and client success stories are highlighted at the beginning of each strategy category section, along with lists of contractors and partners providing MIDD services. On Page 9, the Bridges Program, which provides outreach and engagement in the King County's south and east regions, is featured as a community-based intervention. A story about youth peer partners appears on Page 25, and the experience of one behavior modification class participant is shared on Page 34, as an example of strategies that are intended to divert individuals from jail and unnecessary hospitalizations.

It is our hope that you find the content and format of this report to be engaging and informative. We are open to feedback and encourage all audiences to share what they find useful or interesting, or what information may be missing, as a means of improving our reports.

We invite you to attend a MIDD Oversight Committee meeting, held on the fourth Thursday of each month. A public comment period is included at each meeting. We would like to hear from you! Alternatively, you may contact us at midd@kingcounty.gov. For more information on MIDD renewal, please go to:

<http://www.kingcounty.gov/healthservices/MHSA/MIDDPlan/MIDDReviewandRenewalPlanning.aspx>

We thank you for your interest and support of King County's MIDD.



Johanna Bender
Judge, King County Superior Court,
formerly Judge, King County District Court
Co-Chair



Merril Cousin
Executive Director, Coalition Ending Gender-Based
Violence, formerly the King County Coalition
Against Domestic Violence, Co-Chair



Acknowledgments

Thank you to the citizens of King County, the elected officials of King County, the MIDD Oversight Committee and Co-Chairs, and the many dedicated providers of MIDD-related services throughout King County. As always, a special thank you to those willing to share their personal experiences and photos in this report.

MIDD Oversight Committee Purpose

The Mental Illness and Drug Dependency (MIDD) Oversight Committee was formally established via Ordinance 16077 in 2008. The ordinance approved an oversight plan for the MIDD, including a description of the required membership for the MIDD Oversight Committee and its roles and responsibilities.

The MIDD Oversight Committee is an advisory body to the Executive and Council. Its purpose is to ensure that the implementation and evaluation of the strategies and programs funded by the MIDD sales tax revenue are transparent, accountable, collaborative and effective.

The Committee is a unique partnership of representatives from government and communities, including the health and human services and criminal justice communities. Recognizing that King County is the countywide provider of mental health and substance abuse services, the Committee works to ensure that access to mental health and chemical dependency services is available to those who are most in need throughout the County.

The MIDD Oversight Committee met nine times during the reporting period to monitor program implementation and progress of the MIDD. Six regular meetings were held, along with three additional meetings that focused on MIDD renewal activities. Members of the committee cumulatively contributed 186 hours of service in these meetings. Furthermore:

- The Crisis Diversion Services subcommittee met four times for a total of eight cumulative member hours and 30 cumulative non-member hours.
- The Fund Balance Work Group met five times in 2015 for a total of 130 cumulative member hours and 60 cumulative non-member hours. This does not include time spent by members outside of meetings reviewing and responding to information.
- The Co-Chairs met monthly with County staff for a total of 24 cumulative member hours and 24 cumulative non-member hours. This does not include Co-Chair time spent on MIDD matters outside of meetings, including but not limited to emails and phone calls.
- The MIDD Renewal Strategy Team met monthly with County staff for a total of 98 cumulative member hours and 70 cumulative non-member hours. This does not include time spent by members outside of meetings reviewing and responding to information.

Please note that Oversight Committee members spend time on MIDD matters outside of meetings reading and responding to information provided about MIDD.

Updates Provided and Key Issues Discussed at Meetings

The Oversight Committee was briefed on the following topics during the current reporting period:

- Strategy 1c—Emergency Room Intervention
- Strategy 4a—School-Based Services
- Strategy 10a—Crisis Intervention Team Training
- King County Health and Human Services Transformation “Familiar Faces” Initiative
- Statewide Behavioral Health Integration.

In committee meetings, the following key issues were discussed:

- MIDD Finance and Budget Updates
- Fund Balance Work Group Advisory Recommendations
- MIDD Fund Review and Renewal Planning
- State and Local Legislative Updates
- MIDD Undesignated Fund Balance Survey Results.

Steps to Assess MIDD Strategy Effectiveness

The steps outlined below are intended to provide a basic framework for interpreting the findings presented throughout this report. Strategy success or effectiveness in meeting MIDD policy goals can be measured in a number of different ways. Consider relevant factors for each unique MIDD strategy to assess how well each one met its objectives.

- Step 1** Examine each strategy's performance measurement statistics in tables on each strategy page.
- Were the targets, revised targets or adjusted targets met each year?
 - If not, what explanations are shown to contextualize shortfalls or surpassed expectations?
- Step 2** Review each strategy's related policy goals for relevant outcomes or linkages. Appendix I on Page 53 shows the alignment between strategies and the MIDD policy goals.
- Step 3** Note reported increases or decreases in system use or symptoms, as well as linkages to other initiatives. Brief highlights or supporting narrative appear on each strategy page. Detailed changes in system use over time are shown in Appendix V: Aggregate System Use by Relevant Strategies (see Page 59). The total number of jail bookings, hospital admissions and days are shown for each post period in comparison to the pre period. For symptom reduction, references to detailed findings published in previous MIDD reports are provided for those interested in additional information.
- Step 4** Examine reported results in relation to the targeted reduction goals shown below. These goals were established in September 2008. Because the overall adult jail population declined between 2008 and 2013, an additional five percent reduction per post period was added to the original reduction goals. For psychiatric hospital use, original targeted reductions were based on admissions alone; information on community inpatient psychiatric hospital and Western State days has been provided here as well.

Period	Adults						Youth		
	Jail or Detention Bookings/Days			Harborview ED Admits		Psychiatric Hospital Use		All Measures	
	Incremental	Additional	Cumulative	Incremental	Cumulative	Incremental	Cumulative	Incremental	Cumulative
Post 1	-5%	-5%	-10%	-5%	-5%	-10%	-10%	-10%	-10%
Post 2	-10%	-5%	-25%	-14%	-19%	-8%	-18%	-10%	-20%
Post 3	-10%	-5%	-40%	-13%	-32%	-8%	-26%	-10%	-30%
Post 4	-10%	-5%	-55%	-13%	-45%	-7%	-33%	-10%	-40%
Post 5	-10%	-5%	-70%	-15%	-60%	-7%	-40%	-10%	-50%

- Step 5** Keep these factors in mind when interpreting effectiveness results:
- None of the findings presented in this report can establish causality, as there are too many variables beyond the control of evaluators. Results show only patterns or trends observed in the data.
 - Smaller samples are less likely to show significant results, because there is not enough statistical power to detect meaningful change over chance.
 - It is difficult to find significant improvement if base symptoms or system use is low.
 - Strategies that started later have fewer cases and less time to demonstrate change.
 - Some therapeutic court programs use jail days as sanctions, sometimes related to actions that occurred prior to a participant's MIDD service start. In other strategies, hospital use may increase during the first post period as a result of successful linkage to needed care. Thus, first post period increases in days may be difficult to interpret. Later post period changes may be better indications of effectiveness.
 - System use in the year before starting MIDD services is often quite low for youth. Increases over time, comparing post period counts to those low pre period numbers, are common.
- Step 6** Some of the data provided in this report may suggest a need for strategy revisions. Plan modifications are recommended on Page 52. Please see the contact information on Page 6 in order to make any additional recommendations for future strategy revisions.

Community-Based Mental Health and Substance Use Disorder Intervention Strategies

Paying It Forward With Outreach Beyond the City Limits

Oftentimes people in need of behavioral health help are not aware of services available to them. "Outreach" is the process of raising awareness of available services and making connections between people in need and help that is available. Outreach fills gaps within the public mental health system, linking people to services like counseling, case management and care coordination. Outreach can be conducted anywhere: shelters, day centers, emergency centers, community meals, encampments, faith-based locations, and even in the woods. One key component of outreach is being ready to talk to people in the moment, wherever they are.



Bridges Team members Jessica Dean and Tonia Washington of Valley Cities—Renton.

Two staff from the Bridges Program at Valley Cities Counseling & Consultation, part of the Healthcare for the Homeless network, go where people who need help are. These outreach workers build relationships and trust so that they can provide referrals and other critical connections. One service the Bridges Team provides is assessing people for housing. People experiencing homelessness often want housing, but due to behavioral health issues, may need added supports to remain successfully housed. The team also assists with employment resources, such as résumés and cover letters, and clothes for interviews.

Sometimes the outreach counselors see people on an ongoing basis for a period of time. This process can help their clients move from accessing assistance to becoming self-sufficient. The counselors get to see growth as people who have experienced trauma, setbacks and disappointments move through feelings of shame to re-building their sense of self.

Even when people know about services in an abstract way, they often don't know the details about how to access services. Accessing services can be hard and disheartening for people with few resources or behavioral health issues. It may entail constantly facing rejection, overcoming a sense of hopelessness, or feeling stuck. Advocates in the Bridges Program help people through these challenges by facilitating connections and providing support. One professional calling another can often clear a pathway. People who are feeling disrespected or invalidated can be given tools that will help move them toward the point of standing on their own.

Problem solving in the moment can build a person's self-sufficiency. It may involve taking small steps in the right direction. With the right kind of outreach, however, change is possible and people can access services to improve their lives.

The Bridges Team conducts outreach at sites utilized by people experiencing homelessness, such as camp sites and churches. Due to great distances between service sites and the lower density of homeless populations outside the city of Seattle, the team visits multiple sites as clients frequently shift location. Outreach mobility helps eliminate clients' transportation barriers and increases their continuity of care. The Bridges outreach program offers guaranteed psychiatric appointments within seven days of request, including evaluations and medication management.



By Kimberly Cisson

Agencies Providing MIDD Community-Based Services

Agencies Providing MIDD Community-Based Services	Type*	1a-1	1a-2	1b	1c	1d	1e	1f	1g	1h	2a	2b	3a	13a	14a
Asian Counseling & Referral Service	MH & SUD	X	X				X					X			
Atlantic Street Center	MH	X									X				
Auburn Youth Resources	SUD		X				X								
Cascade Behavioral Health	SUD		X												
Catholic Community Services	MH & SUD	X	X				X						X		
Center for Human Services	SUD		X				X								
Chestnut Health System	MIDD						X								
Community House	MH	X									X				
Community Psychiatric Clinic	MH & SUD	X	X				X				X	X			
Consejo Counseling & Referral Services	MH & SUD	X	X				X				X				
Cowlitz Tribal Treatment	SUD		X				X								
DAWN	MIDD													X	
DESC	MH & SUD	X	X				X				X	X	X		
EvergreenHealth	MH & SUD	X	X				X			X	X				
Evergreen Recovery Services	SUD		X				X								
Evergreen Treatment Services	SUD		X				X						X		
Fairfax Hospital	MH & SUD		X												
Friends of Youth	SUD		X				X								
Guided Pathways – Support (GPS) for Youth & Families	MIDD							X							
Harborview	MH & SUD	X	X	X	X	X	X				X	X	X		X
Hero House	MH	X										X			
Highline Medical Center	MIDD				X										
Integrative Counseling Services	SUD		X				X								
Intercept Associates	SUD		X				X					X			
King County Coalition Against Domestic Violence	MIDD													X	X
King County Sexual Assault Resource Center	MIDD														X
Kent Youth & Family Services	SUD		X				X								
Lifewire	MIDD													X	
Muckleshoot	SUD		X				X								
Multicare Behavioral Health	MH & SUD	X													
Navos	MH & SUD	X	X			X	X				X	X			
New Beginnings	MIDD													X	
New Traditions	SUD		X				X								
Northshore Youth & Family	SUD		X				X								
Perinatal Treatment Services	SUD		X				X								
Pioneer Human Services	MH & SUD	X	X				X								
Plymouth Housing Group	MIDD												X		
Public Health (+)	Partner			X					X						
Recovery Café	MIDD		X												
Recovery Centers of King County	SUD		X				X								
Renton Area Youth Services	SUD		X				X								
Refugee Women's Alliance	MIDD													X	X
Ryther Child Center	MH & SUD	X					X								
Seadrunar	SUD						X								
Sea Mar	MH & SUD	X	X				X				X				
Seattle Area Support Groups	SUD		X												
Seattle Children's (Hospital)	MH	X									X				
Seattle Counseling Services	MH & SUD	X	X				X				X				
Seattle Indian Health Board	SUD		X	X			X					X			
Snoqualmie Indian Tribe	SUD		X				X								
Sound Mental Health (+)	MH & SUD	X	X			X	X				X	X	X		
St. Francis Hospital	MIDD				X										
Therapeutic Health Services	MH & SUD	X	X				X				X				
Transitional Resources	MIDD												X		
TRAC Associates	SUD											X			
Valley Cities Counseling & Consultation	MH & SUD	X	X			X	X				X	X	X		
WA Asian Pacific Islanders Families Against Substance Abuse	SUD		X				X								
WCHS, Inc / Renton Clinic	SUD		X												
YMCA	MH	X									X				
Youth Eastside Services	SUD		X				X								

(+) = Over 30 subcontractors or community clinics receive MIDD funding through these agencies.

* Types of providers include mental health (MH) and substance use disorder (SUD).

This strategy provides treatment services for people who meet clinical and financial criteria for services, but who are otherwise Medicaid-ineligible. By providing continuous access to mental health (MH) services during Medicaid eligibility changes, emotionally and financially costly disruptions to treatment and recovery are prevented. Twenty licensed community MH agencies deliver highly-individualized, consumer-centered services in outpatient settings. Uninsured King County residents of all ages are served under this strategy.

Primary Policy Goal: Reduce incidence and severity of mental illness symptoms

Secondary Policy Goal: Reduce jail, emergency room and psychiatric hospital use

		Annual or Adjusted Targets and Performance Measurement							
Measure	Original Target		Year 1 2008-9	Year 2 2009-10	Year 3 2010-11	Year 4 2011-12	Year 5 2012-13	Year 6 2013-14	Year 7 2014-15
Number of Clients	2,400	Target	2,300	2,400	2,400	2,400	2,400	2,400	2,400
		Actual	2,047	3,481	3,090	4,345	4,612	3,117	2,730
		Percent	89%	145%	129%	181%	192%	130%	114%

Target Adjustments and Notes: Year 1 (11.5 months)

Strategy 1a-1 Key Findings Summary

Symptoms: Mental health treatment providers began submitting symptom measures for the MIDD evaluation in 2010. The Problem Severity Summary (PSS) assessed adult symptomology, while the Children's Functional Assessment Rating Scale (CFARS) provided measures for younger clients. Anxiety and depression were found to be the most common clinical symptoms for both adults and children.

Analyses of symptom data conducted every two years showed that the vast majority of clients remained stable over time. If symptom scores did change, improvements at some point during treatment were much more common (85%) than worsening symptoms (15%). Staying in treatment over time was associated with increased total percentages of adults who reduced their symptoms (up to 42% of all eligible participants).

For young people, extreme issues were rare, but two of every three youth with baselines above the clinical threshold for concern reduced their depression and anxiety scores below that threshold, indicating improved mental health.

Jail Use: Detailed information on system use over time appears in Appendix V, which begins on Page 59. The greatest reduction in total adult jail bookings for participants in this strategy was 62 percent, when jail days also fell by 58 percent. The greatest declines in youth detention bookings (-26%) and days (-8%) were found comparing pre measures to those in the fourth post period. In all other post periods, youth detentions declined slightly, while days increased by as much as 15 percent.

Emergency Department (ED) Use:

Admissions to Harborview's ED decreased year after year, reaching a 36 percent reduction between the pre period and fifth post period. In a small sample analysis, one year reductions in use at other EDs (not Harborview) were found (-12%).

Psychiatric Hospital Use: Reduced hospitalizations, including at Western State, were realized for both adults and youth served by Strategy 1a-1. The pattern in their number of days hospitalized varied by age. Adult days decreased over all periods, but youth days increased after initial first post period reductions.



Increase Access to Community Substance Use Disorder Treatment

1a-2

Assessment, individual and group counseling, and case management are all units of substance use disorder (SUD) treatment services provided to adults in outpatient (OP) settings. Treatment for youth includes all of these components, plus urinalysis. People enrolled in opiate treatment programs (OTP) typically receive daily medications such as methadone in combination with other treatment support. More than 30 provider agencies participated in delivering these services.

Primary Policy Goal: Reduce incidence and severity of SUD symptoms

Secondary Policy Goal: Reduce jail and emergency room use

		Annual or Adjusted Targets and Performance Measurement							
Measure	Revised Target		Year 1 2008-9	Year 2 2009-10	Year 3 2010-11	Year 4 2011-12	Year 5 2012-13	Year 6 2013-14	Year 7 2014-15
Adult Outpatient Units	50,000	Target	47,917	50,000	50,000	50,000	50,000	50,000	50,000
		Actual	36,181	43,751	26,978	30,053	31,409	30,366	20,362
		Percent	76%	88%	54%	60%	63%	61%	41%
Youth Outpatient Units	4,000	Target	3,833	4,000	4,000	4,000	4,000	4,000	4,000
		Actual	10,370	6,617	5,749	6,564	4,254	3,829	2,833
		Percent	271%	165%	144%	164%	106%	96%	71%
Opiate Treatment Program Units	70,000	Target	67,083	70,000	70,000	70,000	70,000	70,000	70,000
		Actual	66,957	82,560	72,677	79,017	88,189	53,791	21,231
		Percent	100%	118%	104%	113%	126%	77%	30%

Target Adjustments and Notes: Year 1 (11.5 months); Original target called for counting number of clients State and federal funds were available and expended first, so fewer treatment units were purchased with MIDD funds. In Year 7, more clients had access to Medicaid funds for SUD treatment, further reducing units purchased by MIDD. New targets for this strategy are recommended on Page 52.

Strategy 1a-2 Key Findings Summary

Symptoms: In February 2013, data from 2,699 adult outpatients showed the top three substances used were: alcohol (55%), marijuana (25%) and cocaine (6%). The one-year abstinence rates were highest for alcohol treatment (26%), with marijuana (24%) and cocaine (20%) slightly lower. A large sample analysis was published in the Year Seven Progress Report (August 2015).

Global Appraisal of Individual Needs (GAIN) information was available in February 2014 for 195 youth, 73 percent of whom were in treatment for marijuana. Average marijuana use "in the past 90 days" fell significantly from 36 days (Pre) to 28 (Post) for 130 youth with data at two time points. About 31 percent of youth (59 of 193) had abstained from marijuana by their second measure.

Jail Use: Adult jail use was cut in half over time for strategy participants in both OP and OTP settings (-51% in days by the fifth post period). For youth, booking reductions were often offset by increases in the number of days detained.

Emergency Department (ED) Use: While those in MIDD-funded OP reduced their use of the ED over time (-32% in Post 5), OTP clients increased use or had fairly modest declines (maximum -10% in Post 3).

Increased Number of Medicaid-Ineligible People Gained Access to SUD Treatment

Over six years, MIDD-funded services enabled 694 youth and 3,895 adults who would not have received treatment services to get the treatment they needed. Due to the Affordable Care Act coming on line in 2014, many of these people became eligible for Medicaid-supported treatment services.



Outreach and Engagement to Individuals Leaving Hospitals, Jails, or Crisis Facilities

1b

This strategy helps people with chronic homelessness, mental illness and addictions get the services they need from community service providers. Through partnerships with Public Health—Seattle & King County, Healthcare for the Homeless, and others, outreach is conducted to people in need of services, with priority serving people leaving hospitals and jails who would be exiting into homelessness. Outreach and engagement efforts employ principles of motivational interviewing, trauma-informed care and harm reduction.

Primary Policy Goal: Reduce jail, emergency room and psychiatric hospital use

Secondary Policy Goal: Link with other Council-directed initiatives

		Annual or Adjusted Targets and Performance Measurement							
Measure	Original Target		Year 1 2008-9	Year 2 2009-10	Year 3 2010-11	Year 4 2011-12	Year 5 2012-13	Year 6 2013-14	Year 7 2014-15
Number of Clients	675 with 5.6 FTE	Target	239	675	675	675	675	675	675
		Actual	435	1,857	1,693	1,530	1,346	1,096	1,074
		Percent	182%	275%	251%	227%	199%	162%	159%

Target Adjustments and Notes: Year 1 (3 - 3.5 months and only 5 FTE)
Blended funds allowed more clients to be served than MIDD funds alone.

Strategy 1b Key Findings Summary

Initiative Linkage: This strategy furthers the goals of King County's Ten-Year Plan to End Homelessness (Ordinance 15284). Strategy 1b links people with services to help them exit homelessness.

The percentage of clients served under this strategy who were experiencing homelessness at the start of their services in MIDD Year Two was 69 percent. By MIDD Year Seven, this figure had risen to 75 percent. Where homeless details were known, one third of clients were experiencing homelessness for the first time at their MIDD service start, another third were intermittently housed, and the final third had experienced chronic homelessness.

Thousands of clients were successfully engaged to address the underlying factors potentially associated with homelessness, yet the cited statistics point to the growing issue of homelessness in the region.

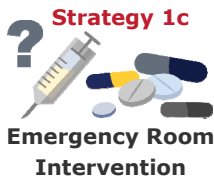
Please see the story about outreach by one strategy provider on Page 9 of this report.

Jail Use: Jail booking reductions for strategy participants in excess of 40 percent were found among those eligible for long-term analysis; days fell more than 35 percent.

Emergency Department (ED) Use: For Strategy 1b participants, total admissions to the Harborview ED were 10 percent less when comparing the pre and fifth post periods. Reductions in non-Harborview ED admissions were found (-6%) for a smaller strategy sample, as shown on Page 67.

Psychiatric Hospital Use: Short-term increases in psychiatric hospitalizations for earlier post periods were followed by a decrease of 37 percent in the fifth post period. The sum of days fell minimally over the long term (-3%).

Treatment Linkage: Within one year of MIDD service starts, 18 percent of strategy clients were linked to mental health care; 44 percent received public sector substance abuse treatment. Sobering service visits held stable for 4,630 people over their first year, from 9,333 (Pre) to 9,140 (Post 1).



Emergency Room Substance Abuse Early Intervention Program

1c

Screening, Brief Intervention and Referral to Treatment (SBIRT) is an evidence-based universal prevention practice used to engage persons who are at early risk for substance use disorders (SUD). The MIDD provides SBIRT for patients admitted to three emergency departments (ED): Harborview, St. Francis and Highline. The SBIRT approach involves establishing rapport with the person and asking to discuss their alcohol/drug use, then providing feedback, enhancing motivation for potential change, and making referrals to treatment if needed.

Primary Policy Goal: Reduce jail and emergency room use

		Annual or Adjusted Targets and Performance Measurement							
Measure	Original Target		Year 1 2008-9	Year 2 2009-10	Year 3 2010-11	Year 4 2011-12	Year 5 2012-13	Year 6 2013-14	Year 7 2014-15
Screenings	6,400 with 8 FTE	Target	3,333	4,800	6,000	5,600	5,600	4,000	4,560
		Actual	2,558	3,344	4,649	3,695	4,422	2,584	2,177
		Percent	77%	70%	77%	66%	79%	65%	48%
Brief Interventions	4,340 with 8 FTE	Target	2,260	3,255	4,069	3,798	3,798	2,688	3,092
		Actual	2,250	4,050	5,475	4,763	3,488	2,869	2,585
		Percent	100%	124%	135%	125%	92%	107%	84%

Target Adjustments and Notes:

Year 1 (5 - 9 months); Years 1 & 2 (6 FTE); Year 3 (7.5 FTE); Years 4 & 5 (7 FTE); Year 6 (5 FTE); Year 7 (5.7 FTE)
Screening numbers fell short of expectations due in part to provider prioritization of quality (time spent) over quantity.

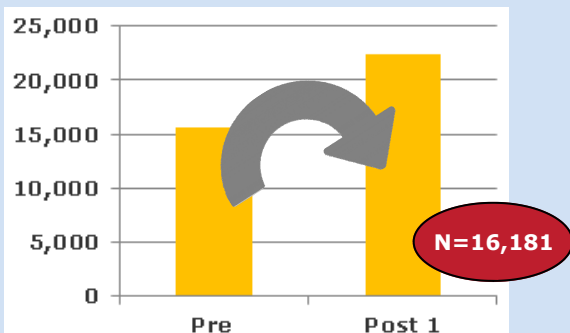
Strategy 1c Key Findings Summary

Emergency Department (ED) Use:

Exclusive of Harborview admissions where SBIRT services marked the start of MIDD services for a person, total ED visits there were reduced for SBIRT participants (-36% by the fifth post period). By contrast, ED visits rose in the first year following MIDD-funded SBIRT services by more than 45 percent at Harborview and by 29 percent at other EDs in King County.

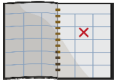
Dutch Shisler Sobering Center Visits Increased

During the first year following initial SBIRT encounters, total sobering services for clients increased from 15,671 to 22,460 (+43%).



Jail Use: Jail bookings and days rose for strategy participants by as much as 18 percent in the first two years following the first recorded SBIRT service. By the third year, jail use began to decline, with the greatest reductions noted in the fourth post period (-40% for bookings and -35% for days). Of the 2,082 clients served before July 2011 and who had any jail use, 61 percent lowered both jail bookings and days over time (64% of Harborview SBIRT clients and 53% of those initially served elsewhere).

Treatment Linkage: One of every five clients who received their first SBIRT service at Harborview Medical Center was linked to publicly-funded SUD treatment within a year of their first SBIRT service. For clients served in the south region of King County, the linkage to SUD treatment rate was 12 percent. Harborview SBIRT clients may be linked to treatment at higher rates, as they are more likely to receive brief ongoing therapy offered only at that location. Having more encounters may increase linkage rates.

Strategy 1d

**Crisis Next Day
Appointments**

Mental Health Crisis Next Day Appointments and Stabilization Services

1d

State-funded crisis stabilization services, including next day appointments (NDAs), are enhanced with MIDD funding to provide additional services such as psychiatric medication evaluations. Following a mental health crisis, medical professionals meet with a person to perform face-to-face reviews to determine the need for medications, recommended medication adjustments and side effect/symptom management. These medical services may also be provided in consultation with primary therapists or case managers.

Primary Policy Goal: Reduce jail, emergency room and psychiatric hospital use

		Annual or Adjusted Targets and Performance Measurement							
Measure	Original Target		Year 1 2008-9	Year 2 2009-10	Year 3 2010-11	Year 4 2011-12	Year 5 2012-13	Year 6 2013-14	Year 7 2014-15
Number of Clients with Enhanced Services	750	Target	688	750	413	285	285	285	634
		Actual	868	960	475	231	291	259	339
		Percent	126%	128%	115%	81%	102%	91%	53%

Target Adjustments and Notes:

Year 1 (11 months); Year 3 (9 months at 60% reduction); Years 4 to 6 (62% reductions); Year 7 (15% reduction)
For nearly four years, state funding for NDAs was severely cut, impacting the capacity to deliver enhanced services. Clients with medical services are counted to approximate the total number clients with enhanced services.

Strategy 1d Key Findings Summary

Jail Use: Reduced jail use peaked for NDA clients during the fourth post period. Aggregate jail bookings dropped from 851 in the pre period to 498 (-41%) and jail days were cut in half from 21,805 to 10,805 for the 2,121 people who were outcomes eligible over that time period. Of the 513 people in this group who had some jail use, 66 percent reduced their jail bookings and 67 percent reduced their jail days. Those who reduced their jail use had received slightly more medical service hours than those who did not, but the differences were not statistically significant.

Emergency Department (ED) Use: For the 1,750 strategy clients eligible for fifth post analysis, 858 (49%) had recorded admissions to Harborview's ED. The total number of admissions for this group was reduced from 1,785 (Pre) to 674 (Post 5), or 62 percent over the long term. As shown on Page 8 of this report, the ultimate goal for ED reductions was 60 percent.

Psychiatric Hospital Use: Only 218 NDA clients out of the 1,750 eligible by the passage of time (12%) had any use of community inpatient psychiatric hospitals or Western State Hospital during the fifth post period. The sum of their admissions fell from 276 in the pre period to 157 in the fifth post (-43%). The number of days hospitalized, however, was reduced by only four percent, from 3,938 days to 3,782. On average, days were reduced from 18 (Pre) to 17 (Post 5) per person served by this strategy.

Treatment Linkages: Several strategies track confirmed linkages to publicly-funded mental health (MH) treatment benefits within a year of MIDD-funded service starts. For clients who received enhanced NDAs, the linkage rate for MH treatment was 32 percent.

Chemical Dependency Professional (CDP) Education and Training

1e

A 2010 workforce development plan was adopted by King County's Department of Community and Human Services to bring more industry-standard evidence-based practices into the substance use disorder treatment system. A key element of the plan involves training professionals in motivational interviewing, a universal skill set expected of all well-qualified CDPs. Additional trainings ensure fidelity to this and other treatment models. The MIDD provides reimbursement for expenses incurred while earning or renewing CDP or prevention professional credentials.

Primary Policy Goal: Link with other Council-directed initiatives

		Annual or Adjusted Targets and Performance Measurement							
Measure	Original and Added Target		Year 1 2008-9	Year 2 2009-10	Year 3 2010-11	Year 4 2011-12	Year 5 2012-13	Year 6 2013-14	Year 7 2014-15
Number of Reimbursed Trainees	125	Target	120	125	125	125	125	125	125
		Actual	165	194	344	349	374	341	345
		Percent	138%	155%	275%	279%	299%	273%	276%
Number of Workforce Development Trainees	250	Target	0	0	0	250	250	250	250
		Actual	0	0	0	253	400	369	482
		Percent	N/A	N/A	N/A	101%	160%	148%	193%

Target Adjustments and Notes: Year 1 (11.5 months); Workforce development target added in Year 4

Strategy 1e Key Findings Summary

Initiative Linkage: A 2005 Mental Health Recovery Plan (King County Ordinance 15327) called for 1) consumer-centered services and 2) strengths-based assessment and treatment planning. Professionals and trainees who learn motivational interviewing techniques through Strategy 1e are better able to meet clients where they are and to help facilitate changes chosen by clients. Clinical supervision then supports new trainees to deliver the evidence-based treatment methods with fidelity. Courses in treatment planning facilitate development of plans that are measurable, attainable, time-limited, realistic and specific. Together with new courses (see below), King County's CDP workforce remains focused on recovery.

Common Elements Treatment Approach (CETA)

A learning collaborative trained 20 clinicians, four supervisors and three consultants in CETA. This modularized cognitive-behavioral therapy offers a brief, structured intervention focused on symptom reduction for people exposed to trauma. An external evaluation of CETA found symptom score reductions for depression (-42%) and anxiety (-39%).

\$ The average reimbursement per CDP/T or CPP was approximately \$1,000.

Training Evaluations: Data collected immediately following each training are compared to follow-ups done 30 days later. About half of all trainees rated their training experience. Positive gains in knowledge and skills were consistently evident for the majority of those completing evaluations. Respondents also highly rated the quality and relevance of the courses offered.

Narrative responses provide insight into the skills and resources clinicians have gained by attending MIDD-funded trainings:

- "I've changed my language and started asking more open-ended questions to invite change talk. I've worked hard to stop trying to FIX the problem."
- "...remember the importance of letting a client go through the process."
- "The tools we reviewed were most helpful, for example the professional development template and the books we received."

Parent Partner and Youth Peer Support Assistance Program

1f

A family support organization, Guided Pathways—Support (GPS) for Youth and Families, was developed in 2012 to provide services for families, by families with children or youth experiencing serious emotional or behavioral problems and/or who have substance abuse issues. Strategy 1f empowers families with information and support to promote self-determination and family well-being.

Primary Policy Goal: Link with other Council-directed initiatives

		Annual or Adjusted Targets and Performance Measurement							
Measure	Revised Target		Year 1 2008-9	Year 2 2009-10	Year 3 2010-11	Year 4 2011-12	Year 5 2012-13	Year 6 2013-14	Year 7 2014-15
Number of Individually Identified Clients	400	Target	0	0	0	0	0	200	300
		Actual	0	0	0	0	0	137	182
		Percent	N/A	N/A	N/A	N/A	N/A	69%	61%

Target Adjustments and Notes: Year 6 (startup); Year 7 (fully staffed 1/1/2015)
The implemented program design differed from the original MIDD conception.
A second target, to serve 1,000 people per year in group settings, is not shown above.

Strategy 1f Key Findings Summary

Initiative Linkage: The King County Strategic Plan adopted in 2010 (Ordinance 16897) promotes “opportunities for all communities and individuals to realize their full potential.” In alignment with this initiative, GPS engages groups and individuals throughout King County to provide family assistance and support. While the number of people in individualized services has lagged below target during the startup period for this strategy, the number of people served through group outreach and education has exceeded expectations. This strategy also funds a parent partner specialist who facilitates monthly Parent Partner Network meetings.

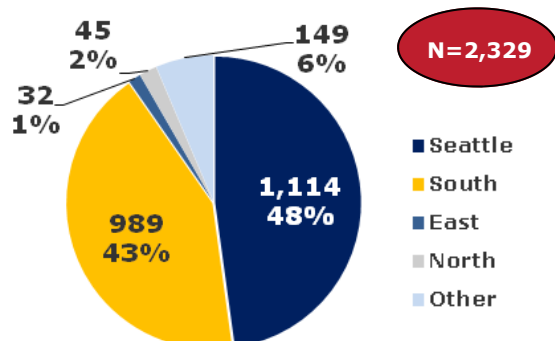
Other Outcomes: Key outcomes for Strategy 1f involve increasing protective factors for families and youth served, while decreasing their risk factors, by increasing knowledge of service systems and connections to natural supports. A total of 710 client visits were recorded for 289 unique people since 2013. The average number of support hours provided per person was nearly eight hours. In the grid below, services per visit are listed in descending order of frequency. Multiple services per client visit were possible.

Services Provided	N	Percent
Assisted in obtaining services*	568	80%
Systems navigation	487	69%
Life skills	466	66%
Gaining advocacy skills	359	51%
Self care	349	49%
Strengths assessment	331	47%
Basic needs assistance	197	28%
Identifying natural supports	171	24%

*Including treatment for mental illness and substance use disorders, as well as special education and other benefits.

Please see the story about GPS’ new Youth Peer Partner on Page 25 of this report.

GPS Surpassed Goal of Serving 1,000 People in Group Services in MIDD Year Seven



Strategy 1gOlder
Adults
Prevention

Prevention and Early Intervention Mental Health and Substance Abuse Services for Adults Age 50+

1g

Older adults receiving primary medical care through a network of “safety net” clinics have access to screening for depression, anxiety and substance use disorders (SUD). When needed, short-term behavioral health interventions are made available for people who are age 50 or older. This strategy continues to lead healthcare integration efforts and serves as a model for incorporating behavioral health care into primary care settings.

Primary Policy Goal: Reduce incidence and severity of mental illness or SUD symptoms

Secondary Policy Goal: Reduce emergency room use

		Annual or Adjusted Targets and Performance Measurement							
Measure	Original Target		Year 1 2008-9	Year 2 2009-10	Year 3 2010-11	Year 4 2011-12	Year 5 2012-13	Year 6 2013-14	Year 7 2014-15
Number of Clients	2,500 with 7.4 FTE	Target	1,875	2,196	2,196	2,196	2,196	2,196	2,196
		Actual	1,805	2,495	2,993	3,635	4,231	4,892	8,933
		Percent	96%	114%	136%	166%	193%	223%	407%

Target Adjustments and Notes: Year 1 (9 months); Years 1 to 7 (6.5 FTE)

Strategy 1g Key Findings Summary

Symptoms: As reported in February 2010, over half of all Strategy 1g participants with depression scores at two points in time reduced their symptoms (N=106). Further analysis with larger samples in August 2011 showed reductions in depression symptoms for 68 percent (N=1,096) and reductions in anxiety for 65 percent (N=742). The people who had more severe symptoms initially were more likely to improve over time. On average, successful outcomes for people served by this strategy were realized in as few as ten service visits or seven service hours (February 2012).

In August 2013, Public Health—Seattle & King County, a key partner in this strategy, reported that in cases where symptoms were not improving, 74 percent of patients received a psychiatric consultation. For most clients who received services beyond initial screening, those with more contacts and more service minutes had greater symptom reduction or stabilization.

Depression typically stabilized below the clinical threshold for concern with as few as eight hours of treatment (N=1,229), as reported in February 2014.

Emergency Department (ED) Use: Only those clients who engaged in mental health or SUD services beyond initial screening visits were entered into the outcomes analysis sample. Reductions in the total number of visits to the ED at Harborview were seen in each post period studied, with the greatest decline in the fifth post period where ED admissions dropped by 30 percent, from 589 (Pre) to 414 (Post 5), for the 341 people eligible by the passage of time and system use.

A small sample analysis explored short term changes in EDs statewide. In the new data set, first-year Harborview reductions of 23 percent were contrasted by an insignificant rise of three percent elsewhere in the state. Please see Page 67 for detailed results.

Treatment Linkages: Analysis of linkage data revealed that relatively few clients appeared to need additional publicly-funded treatment services. For mental health benefits, linkages were confirmed for 16 percent of the 4,105 people eligible within a year of their MIDD service start. The linkage figure for SUD treatment was much lower at five percent.

Strategy 1h

Expand Availability of Crisis Intervention and Linkage to Ongoing Services for Older Adults

1h

The Geriatric Regional Assessment Team (GRAT) delivers community-based crisis intervention services for adults age 60 and older. In response to calls from police, other first responders, and other community referents, the team is deployed countywide to assess those in crisis and connect them with appropriate service providers. The GRAT often helps divert clients from hospitals and evictions. With MIDD funding, the team has hired additional geriatric specialists to serve more clients in a timely manner and has increased collaboration with law enforcement and King County Designated Mental Health Professionals.

Primary Policy Goal: Reduce emergency room and psychiatric hospital use

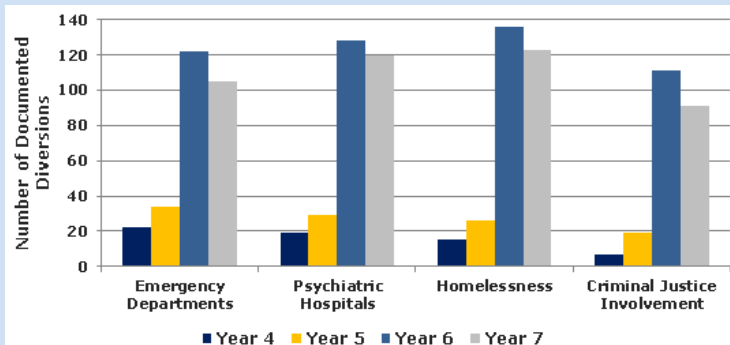
		Annual or Adjusted Targets and Performance Measurement							
Measure	Original Target		Year 1 2008-9	Year 2 2009-10	Year 3 2010-11	Year 4 2011-12	Year 5 2012-13	Year 6 2013-14	Year 7 2014-15
Number of Clients	340 with 4.6 FTE	Target	312	340	258	258	258	258	258
		Actual	327	444	424	326	435	443	294
		Percent	105%	131%	164%	126%	169%	172%	114%

Target Adjustments and Notes: Year 1 (11 months); Years 3 to 7 (3.5 FTE)

Strategy 1h Key Findings Summary

Specialized Outreach Crisis Intervention Helps Divert Older Adults from Costly Outcomes

In January 2012, the GRAT began tracking diversions of referred older adults from homelessness and other costly dispositions like psychiatric hospitals. The first two years of reporting counted relatively few diversions, but recent reports indicate that nearly all clients avoid entering at least one of the expensive systems or circumstances shown at right.



Emergency Department (ED) Use: After first-year increases in GRAT client visits to Harborview ED, each subsequent post period showed reductions as great as 90 percent in the fifth post period. While this period had only 53 people eligible by time and usage as explained on Page 3, the average reduction from 1.9 admissions (Pre) to 0.2 (Post 5) was statistically significant. Only nine percent of GRAT clients had used the Harborview ED during the MIDD evaluation, so it is recommended that future studies look to alternate data sources to fully understand ED utilization for this MIDD population.

Psychiatric Hospital Use: On average over the past six years, only four percent of the clients seen by GRAT were psychiatrically hospitalized. This low incidence rate led to relatively few clients being eligible for change over time analysis. In all post periods except the last, where the sample size was less than 10 people, both hospitalizations and days in the hospital tended to increase over time. One explanation for this finding may be GRAT discovery of clients with previously undiagnosed dementia, resulting in long inpatient stays after their initial MIDD services contact.

The workload reduction strategy was designed to increase the number of direct services staff in community mental health (MH) agencies. The frequency and quality of services delivered to clients is improved when caseloads are reduced. Thus, by funding more or different staff positions, overall caseload sizes can be reduced. This strategy is aligned with goals of the Recovery and Resiliency-Oriented Behavioral Health Services Plan adopted in King County through Ordinance 17553 in April 2013.

Primary Policy Goal: Link with other Council-directed initiatives

		Annual or Adjusted Targets and Performance Measurement							
Measure	Original Target		Year 1 2008-9	Year 2 2009-10	Year 3 2010-11	Year 4 2011-12	Year 5 2012-13	Year 6 2013-14	Year 7 2014-15
Number of Agencies Participating	16	Target	16	16	16	16	16	16	16
		Actual	16	16	16	17	17	16	16
		Percent	100%	100%	100%	106%	106%	100%	100%

Strategy 2a Key Findings Summary

Initiative Linkage: The workload reduction strategy allocated funds for MH provider agencies to implement new staffing plans intended to improve recovery efforts. As stated in the Recovery and Resiliency-Oriented Behavioral Health Services Plan, "...services will evolve to better support the recovery and resiliency of King County residents living with these challenges." The plan is further aligned with guiding principles of the King County Strategic Plan with core values and priorities to be collaborative, service-oriented, results-focused, accountable, fair and just, innovative, and professional.

Prior to the MIDD, at least 869 direct services staff members were employed by MH provider agencies participating in this strategy. As of September 2010, the number of direct services staff had risen to 1,160. Of the 291 additional staff brought on across the MH system to improve staff-to-client ratios and quality of care, over 45 percent were attributed to MIDD funding in summary reports submitted by each agency. By March 2011, total staffing attributed to workload reduction was 145 people, despite state budget cuts which led seven agencies to eliminate more than 75 staff positions.

A study by MIDD evaluators in 2012 assessed the impact of MIDD-funded staff increases on staff-to-client ratios. Data from 2011 for five agencies showed that each staff member served 17 to 57 clients, depending on the agency, with an average of 40 clients per staff member. Highs and lows over a four-year period balanced out such that overall caseloads were reduced from 42, on average, down to 35 clients per direct services staff member (-17%).

In the current reporting period, six agencies updated their workload reduction plans to include new direct staff positions such as peer specialists, screeners, youth counselors, housing specialists and care coordinators. One agency reported a 25 percent decrease in caseload size as a result of MIDD funding.

Despite MIDD initiatives to reduce caseloads, two key issues continue to drive agency caseloads: 1) the influx of newly eligible clients through the Affordable Care Act, and 2) the challenges of hiring and retaining qualified staff to provide mental health care.

The 2014 target for providing services to clients within seven days of hospital discharge was 84 percent; from jail was 76 percent. By year end, actual achievement of these goals was 81 percent for hospital discharges and 78 percent for jail releases.

Employment Services for Individuals with Mental Illness and Substance Use Disorders

2b

Supported employment (SE) programs help people who are enrolled in community mental health (MH) and substance use disorder (SUD) treatment agencies find and maintain competitive-wage jobs. Following the evidence-based SE model developed at Dartmouth College, these programs focus on zero exclusion, rapid and individualized job searches, customized job development in the client's community, and post-employment support.

Primary Policy Goal: Link with other Council-directed initiatives

Measure	Original Target	Annual or Adjusted Targets and Performance Measurement							
			Year 1 2008-9	Year 2 2009-10	Year 3 2010-11	Year 4 2011-12	Year 5 2012-13	Year 6 2013-14	Year 7 2014-15
Number of Clients	920 for both MH/SUD	Target	671	700	700	700	700	700	700
		Actual	734	820	793	834	884	935	871
		Percent	109%	117%	113%	119%	126%	134%	124%

Target Adjustments and Notes: Year 1 (11.5 months); Years 1 to 7 (MH clients only)
A pilot program for SUD clients began in 2015.

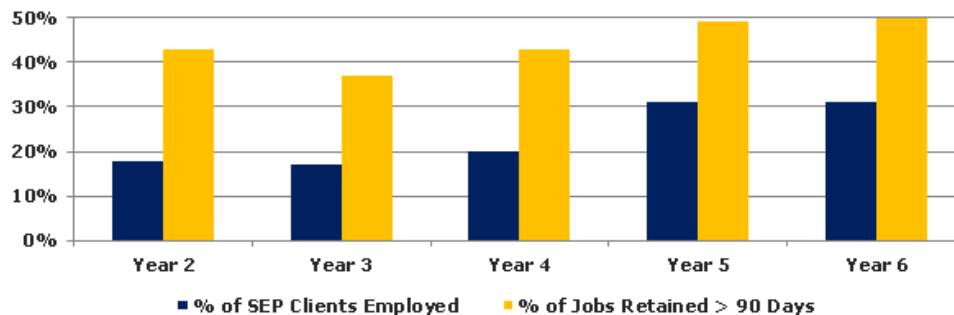
Strategy 2b Key Findings Summary

Initiative Linkage: Linked initially with the Mental Health Recovery Plan (2005) and later with the Recovery and Resiliency-Oriented Behavioral Health Services Plan (2012), MIDD Strategy 2b helps people in recovery to find and keep mainstream jobs.

Jobs: Prior to 2012, historical data showed that less than three percent of King County's publicly-funded MH treatment recipients gained employment during their benefit period. In 2012, the rate of new employment for persons receiving these year-long benefits rose to six percent. For clients actively enrolled in both a MH benefit and an SE program, employment rates rose from 18 percent as reported in MIDD Year Two to 31 percent in MIDD Year Six, as shown below.

The portion of SE jobs retained for at least 90 days rose from a low in MIDD Year Three of 37 percent to a high of 50 percent in MIDD Year Six. Of the 271 clients with one or more jobs in the sixth year, 177 (65%) kept at least one job more than 90 days.

The Percentage of SE Clients Employed Nearly Doubled Over Five Years



After demonstrating success with clients experiencing mental health challenges, the SE concept was expanded in 2015 to serve clients in SUD recovery. Given the late start for this pilot program, clients served were included in the total count shown above. A new target for MIDD Year Eight is proposed on Page 52.



Supportive Services for Housing Projects

3a

Overcoming homelessness can be especially challenging for people with mental illness and/or substance abuse issues. Research has shown that providing supportive services within housing programs increases the likelihood that people will remain safely housed for longer periods of time, enhancing their chances of maintaining successful recoveries. Examples of supportive services are housing case management, group activities and individualized life skills assistance.

Primary Policy Goal: Reduce jail, emergency room and psychiatric hospital use

Secondary Policy Goal: Link with other Council-directed initiatives

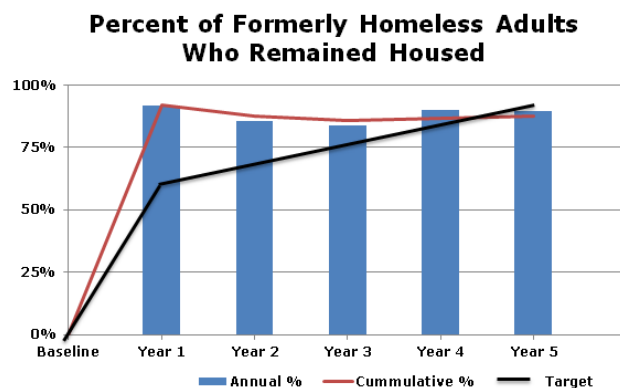
		Annual or Adjusted Targets and Performance Measurement							
Measure	Revised Target		Year 1 2008-9	Year 2 2009-10	Year 3 2010-11	Year 4 2011-12	Year 5 2012-13	Year 6 2013-14	Year 7 2014-15
Number of Clients	Capacity grew annually until 2014	Target	70	251	445	553	614	690	690
		Actual	114	244	506	624	787	869	772
		Percent	163%	97%	114%	113%	128%	126%	112%

Target Adjustments and Notes: Year 1 (6 months)

Strategy 3a Key Findings Summary

Initiative Linkage: Linked with the Ten-Year Plan to End Homelessness in King County, Strategy 3a grew by nearly 400 percent from 2009 to 2014, from 140 to 690 "beds." Annual capacity to provide housing with supportive services grew annually until 2014. In this reporting period, renewal funding was granted to existing providers.

Housing Stability: Typically one in four exits from supportive housing is positive, including moving to independent or less intensive housing. Other exits may be due to clients' unmet medical or psychiatric needs, non-compliance with rules, criminal activity, or even client death. The good news is that nearly 90 percent of supportive housing clients remained housed over time.



Jail Use: About half of all clients housed in programs with MIDD support services had some contact with King County's criminal justice system. Remarkable jail use reductions were achieved by MIDD supported housing clients over time. For example, of the 910 clients eligible for a third post analysis, 457 had jail use data, and they collectively reduced jail bookings 60 percent, from 1,268 (Pre) to 508 (Post 3). The total number of days this group was incarcerated fell by 55 percent. Jail use was reduced by more than 70 percent (Post 5) for clients housed by Strategy 3a before October 2010.

Emergency Department (ED) Use: Harborview ED use was reduced in all five post periods studied, with the greatest reduction (~45%) in the second year after clients began services. Using a new data source, first-year reductions of 19 percent in admissions at other area hospitals (not Harborview) were found.

Psychiatric Hospital Use: One in five people in this strategy had utilized the psychiatric hospital system. The best reductions were in the first year after becoming housed for both admissions (~49%) and days (~54%).



This strategy supports services for individuals dealing with the trauma of domestic violence (DV), with community agencies providing 1) screening for mental illness and substance misuse, 2) therapeutic counseling by staff mental health (MH) professionals, and 3) consultation with DV advocates and others on issues pertaining to MH and substance abuse. System coordination services are included in this strategy.

Primary Policy Goal: Reduce incidence and severity of mental illness symptoms

Secondary Policy Goal: Link with other Council-directed initiatives

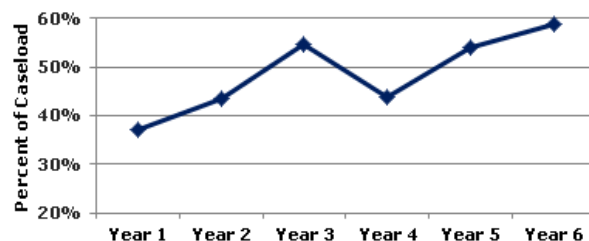
		Annual or Adjusted Targets and Performance Measurement							
Measure	Revised Target		Year 1 2008-9	Year 2 2009-10	Year 3 2010-11	Year 4 2011-12	Year 5 2012-13	Year 6 2013-14	Year 7 2014-15
Number of Clients	560-640	Target	240	700	560	560	560	560	560
		Actual	197	489	517	514	583	558	595
		Percent	82%	70%	92%	92%	104%	100%	106%

Target Adjustments and Notes: Year 1 (3 - 7 months); Years 1 & 2 Target = 700 - 800
Target was adjusted to reflect 20% reduction in original funding plan.

Strategy 13a Key Findings Summary

Initiative Linkage: Linked with the 2010 King County Strategic Plan, Strategy 13a supports "safe communities and accessible justice systems for all" by offering survivors of DV, including children, psychosocial resources to help end the cycle of violence. Since the MIDD began, the portion of DV clients served by this strategy who identified as refugees or immigrants rose from 37 to 59 percent (see below). These clients received culturally-relevant MH services in their own languages.

Immigrants/Refugees Served at High Rate



Recent Changes in Screening Results

Comparing the current year to last year, a higher percentage of people offered screening services were willing to participate (78%, an increase of 9%). The percentage who screened negative, or without need for follow-up services, also increased from 19 percent to 23 percent.

Symptoms: As reported in August 2011, clients became eligible for symptom reduction outcomes after three separate months of therapy sessions. Of the 243 people eligible at that time, 202 (83%) agreed or strongly agreed that they were better able to manage stress in their lives.

In February 2012, additional clients provided evidence of increased coping mechanisms in surveys collected throughout the year. Every client agreed or strongly agreed with survey statements about the positive role of their MIDD therapist in helping them with stress management, decision-making, and self-care.

In the final year of using the original MIDD outcomes tool, 85 client or clinician-rated surveys were submitted. Most respondents (73%) felt they could better manage their stress after therapy (February 2013).

The therapists supported by Strategy 13a worked proactively with the systems coordinator over a two-year period to adopt new standardized outcomes measures based on symptoms. The chosen measures have yet to be validated for DV survivors and this particular service model (brief therapy on-site at DV agencies). Data will become available for analysis in 2016.

Strategy 14aSexual
Assault
Services**Sexual Assault and
Mental Health Services****14a**

This strategy supports trauma informed therapy services for survivors of sexual assault. By blending MIDD funds with other sources of revenue, providers can offer therapy to more of their clients. Universal screening for mental health (MH) issues and/or substance use disorders (SUD) is another key component of this strategy. In conjunction with Strategy 13a, a systems coordinator provides ongoing cross-systems training, policy development, and consultation to bridge the gaps between the MH and drug abuse treatment agencies and the fields of domestic violence (DV) and sexual assault (SA) advocacy.

Primary Policy Goal: Reduce incidence and severity of mental illness symptoms

Secondary Policy Goal: Link with other Council-directed initiatives

Measure	Revised Target	Annual or Adjusted Targets and Performance Measurement							
			Year 1 2008-9	Year 2 2009-10	Year 3 2010-11	Year 4 2011-12	Year 5 2012-13	Year 6 2013-14	Year 7 2014-15
Number of Clients	170	Target	260	400	170	170	170	170	170
		Actual	179	364	301	387	413	348	358
		Percent	69%	91%	177%	228%	243%	205%	211%

Target Adjustments and Notes: Year 1 (5 - 9 months); Years 1 & 2 Target = 400
Target was amended to reflect MIDD portion of service delivery budget.

Strategy 14a Key Findings Summary

Symptoms: Previously published evidence on outcomes for Strategy 14a is shown below.

August 2011: For 54 children and 26 adults, more than 88 percent had positive overall outcomes. Negative symptoms were reduced for 17 adults (65%).

February 2013: For 53 adults with outcomes data since the beginning of the MIDD, 49 (92%) achieved successful outcomes by meeting two or more of these metrics: understanding their experience, coping skills, symptom reduction and achieving treatment goals.

August 2013: In 2012, one sexual assault agency reported that 90 percent of clients increased their coping skills, reduced negative symptoms and/or met treatment goals.

February 2014: For youth, 29 of 32 (90%) had achieved positive outcomes related to emotional stability and behavior change during MIDD Year Five. Positive outcomes, including symptom reduction, were achieved by 71 of 80 adults (89%) in that period.

Trauma-Focused Care Nurtures Resiliency

King County's 2010 Recovery and Resiliency-Oriented Behavioral Health Services Plan speaks to the need to nurture people's inner capacity to successfully meet life's challenges. The trauma-focused therapy provided by Strategy 14a has been shown to effectively reduce debilitating symptoms resulting from sexual assault. Two agencies provide services using empirically-supported principles. A third organization uses a modified approach more suitable for their specific population.

Systems Coordination Efforts Continue

Through workshops, resource development, information dissemination, and focus group facilitation, the Systems Coordinator for Strategies 13a and 14a continued to help diverse agencies explore new ideas and to find common ground. In MIDD Year Seven, 40 consultations were provided, along with six trainings for 192 participants.

Half of all strategy clients in the past three years were immigrants or refugees.

Strategies with Programs to Help Youth

Guided Pathways—Support (GPS) for Youth and Families Added a Youth Peer Program Coordinator to Their Staff in 2015

Several strategies listed in the MIDD community-based care category also have youth-serving programs. One example is Strategy 1f—Parent Partner and Youth Peer Support Assistance Program. In 2015, GPS hired a new Youth Peer Program Coordinator. Ashley is a 26-year-old mother of four children who knows intimately many of the challenges faced by young people for whom she now advocates.

Ashley's parents split up when she was young. Her mother worked a lot and had mental health issues. Ashley experienced verbal, mental and physical abuse at home. As one of eight siblings, Ashley felt overwhelmed, had few social supports, and eventually became gang-involved. After a particularly poignant letdown by her mother, Ashley contacted her father and moved back to Washington from Louisiana.

Once here, she continued to struggle, becoming pregnant at 16, married at 18, then homeless with her children at 23. Ashley found shelter, but struggled with feelings of failure, and attempted suicide multiple times. Feeling misunderstood by counselors, she turned to her father for help.

Eventually she learned about peer specialists and felt she could use her own experiences to help others. She had learned from her father that she could "show people love and embrace them" in a non-judgmental way. Ashley recognizes that she is not at GPS to diagnose or medicate. Having learned Motivational Interviewing, Ashley is able to support people in their self-directed search for what they want out of life.

Strategy 1f

**Parent
Partners
Family
Assistance**



Ashley builds trusting relationships with youth, goes to court with them, and follows them as they make positive progress. She often stays in touch through texting, helping youth to build resilience with her thoughtful messages.

Peers see the world through a different lens than professionals. As Ashley works on her own wellness and recovery, she helps others walking similar pathways.



GPS Youth Peer Ashley Wrightsman-Peoples

Story and Photo by Kimberly Cisson

Other Agencies Providing MIDD Youth Services	Type	4a	4b	4c	4d	5a	6a	7a	7b	8a	9a	13b
Auburn Youth Resources	SUD			x								
Center for Human Services	SUD			x			x					
Community Psychiatric Clinic	MH & SUD						x					
Crisis Clinic (+)	MH				x							
Friends of Youth	SUD			x								
Kent Youth & Family Services	SUD			x								
Neighborcare Health	MIDD			x								
Northshore Youth & Family	SUD			x								
Puget Sound Educational Service District	Partner			x								
Seattle Children's (Hospital)	MH			x								
Sound Mental Health (+)	MH & SUD						x					x
Superior Court, Juvenile Division	Partner					x				x	x	
Therapeutic Health Services	MH & SUD			x			x					
Valley Cities Counseling & Consultation	MH & SUD						x					
YMCA	MH								x			

(+) = Subcontractors also receive MIDD funding through these agencies.

Implementation delays

The earliest identification of youth with mental health (MH) or substance use disorders (SUD) often occurs within school settings. Strategy 4c supports partnerships between local treatment agencies and neighboring schools, serving youth ages 11 to 15 years. Agency staff are integrated at selected middle schools to provide services that include indicated prevention and early intervention, plus screening, brief intervention and referral to treatment. Technical support is also made available to these schools by the Youth Suicide Prevention Program to bolster crisis plans and develop suicide prevention programs using best practices.

Primary Policy Goal: Reduce incidence and severity of mental illness or SUD symptoms

Secondary Policy Goal: Divert youth from initial or further justice system involvement

		Annual or Adjusted Targets and Performance Measurement							
Measure	Original Target		Year 1 2008-9	Year 2 2009-10	Year 3 2010-11	Year 4 2011-12	Year 5 2012-13	Year 6 2013-14	Year 7 2014-15
Number of Youth	2,268 with 19 programs	Target	0	0	1,550	1,550	1,550	1,550	1,550
		Actual	0	0	1,896	1,410	1,510	1,213	1,031
		Percent	N/A	N/A	122%	91%	97%	78%	67%

Target Adjustments and Notes: Years 3 to 7 (only 13 programs funded)

This strategy served 19,401 additional youth and families through group activities in MIDD Year 7.

Strategy 4c Key Findings Summary

Symptoms: As reported in August 2013, Global Appraisal of Individual Needs short screener (GAIN-SS) data for 39 students at one Strategy 4c school showed a higher incidence of internalizing disorders such as depression and anxiety (46%), than externalizing disorders like attention deficit or conduct problems. Very few (3%) scored high for substance use disorders (SUD).

In February 2015, it was reported that of the 1,043 youth served by this strategy who were eligible for outcomes, 109 (10%) had initial GAIN-SS data. In this sample, 60 percent scored high on anxiety or depression; 13 percent had high SUD screens. Data on change over is not yet available for analysis.

Detention Use: Out of the 2,037 Strategy 4c students eligible for first-year outcomes, only 28 (1%) had any utilization of King County's juvenile detention system. For this very small sample, bookings rose over the short term from six (Pre) to 50 (Post 1), while days increased from 39 to 783.

Survey Shows Strategy 4c Students More Aware of Help Available to Them

The Washington State Healthy Youth Survey (HYS) from 2012 was analyzed within the context of MIDD Strategy 4c, and detailed results were provided in February 2015. Of particular interest, the Healthy Youth Survey indicated that 90 percent of 8th graders did not drink alcohol. Of those who used alcohol, binge drinking was higher on average in 4c schools than in King County, but less than statewide. The incidence for depression was about 25 percent both statewide and in 4c schools. Suicidal thoughts were slightly lower in 4c schools than in King County as a whole. In 4c schools, 69 percent of 8th graders were aware of adults available to help them, versus only 46 percent countywide.

Summary data from the 2014 HYS may be examined for inclusion in future reports.



In October 2014, Strategy 4c contracts set to expire in June 2015 were extended through December 2016 for continuity of services pending renewal decisions.



School-Based Suicide Prevention

4d

In the 2012 Healthy Youth Survey, approximately 11,600 King County high school students (14% of all students) said they had made a plan to commit suicide within the past 12 months. In an effort to reduce alarming statistics such as these, MIDD youth suicide prevention trainings are delivered to both school-aged youth and concerned adults throughout the county. Teen trainings offer a safe place to talk openly about suicide, self-harm, depression, concern for friends, and how to ask for and get help. Under this strategy, school districts also have opportunities to improve safety planning and their written crisis response policies.

Primary Policy Goal: Link with other Council-directed initiatives

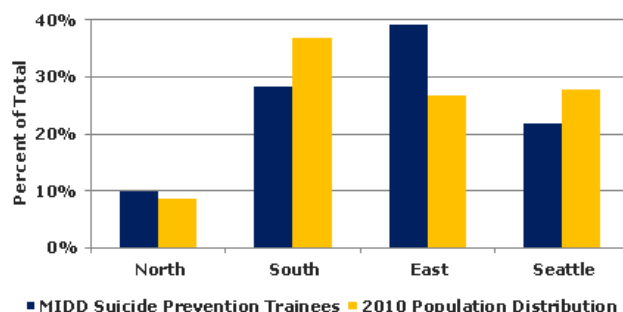
		Annual or Adjusted Targets and Performance Measurement							
Measure	Revised Target		Year 1 2008-9	Year 2 2009-10	Year 3 2010-11	Year 4 2011-12	Year 5 2012-13	Year 6 2013-14	Year 7 2014-15
Number of Adults	1,500	Target	192	1,500	1,500	1,500	1,500	1,500	1,500
		Actual	1,486	688	1,065	633	1,746	1,005	1,072
		Percent	774%	46%	71%	42%	116%	67%	71%
Number of Youth	3,250	Target	3,115	3,250	3,250	3,250	3,250	3,250	3,250
		Actual	4,764	7,600	7,873	8,129	8,634	9,721	8,530
		Percent	153%	234%	242%	250%	266%	299%	262%

Target Adjustments and Notes: Year 1 (11.5 months); Year 1 Target = 200 adults
Blended funds allowed more clients to be served than MIDD funds alone.

Strategy 4d Key Findings Summary

Initiative Linkage: This strategy links with King County's Strategic Plan to support safe communities. Over the past six years, trainings reached nearly three times as many youth as expected. For adults, however, attendance at the contracted 40 trainings per year has lagged below expectations. A corrective action plan was developed in 2012. Despite efforts to engage more adults, the provider only met the target one time after it was raised in 2009 to match the first year's success. More people in the east region of the county have received suicide prevention training over all MIDD years.

County's East Region Trained at Highest Rate



Early Research Demonstrated Program Effectiveness in Increasing Knowledge

The suicide prevention curriculum for youth was adopted after assessments of 2,503 youth who attended MIDD trainings in 2009 showed statistically significant increases in knowledge and/or awareness in the following content areas:

- Teen Link (a teen crisis help line)
- Coping mechanisms
- Warning signs for people who may be suicidal
- How to help if someone seems suicidal.

For adults, 179 evaluations were analyzed and demonstrated training effectiveness in increasing knowledge about:

- Rates and incidence of youth suicide
- Signs of depression
- Suicide warning signs
- Resources and ways to help.

Expand Assessments for Youth in the Juvenile Justice System

5a

Accurately assessing youth involved with the juvenile justice system for mental health (MH) and/or substance use disorder (SUD) issues is the capstone of Strategy 5a. The Juvenile Justice Assessment Team (JJAT) provides many screening and evaluation options for youth, including: triage, consultation, MH and SUD assessments and psychological evaluations. Referrals to psychiatric and neuropsychological evaluations within the community are also provided. This team helps teens reconnect with their families, schools and communities, as well as with appropriate treatment services to meet their behavioral health needs.

Primary Policy Goals: Divert youth from justice system involvement and reduce detentions

		Annual or Adjusted Targets and Performance Measurement							
Measure	Original or Revised Target		Year 1 2008-9	Year 2 2009-10	Year 3 2010-11	Year 4 2011-12	Year 5 2012-13	Year 6 2013-14	Year 7 2014-15
Number of Assessments Coordinated	1,200 (Revised)	Target	0	250	500	500	500	750	833*
		Actual	0	407	580	856	1,467	790	841
		Percent	N/A	163%	116%	171%	293%	105%	101%
Number of Psychological Services	200	Target	0	100	200	200	200	117	200
		Actual	0	32	98	209	186	101	311
		Percent	N/A	32%	49%	105%	93%	86%	156%
Number of Mental Health Assessments	140	Target	0	70	105	140	140	117	140
		Actual	0	124	143	128	123	116	139
		Percent	N/A	177%	136%	91%	88%	99%	99%
Number of Full SUD Assessments	165	Target	0	82	145	165	165	165	165
		Actual	0	251	234	420	291	225	190
		Percent	N/A	306%	161%	255%	176%	136%	115%

Target Adjustments and Notes: Year 2 (50% capacity); Years 3, 6 & 7 (staff vacancies)

The target for coordinations was 500 in Years 2 to 5, increasing in Year 6 to account for inclusion of quick screenings.

Strategy 5a Key Findings Summary

Symptoms: In August 2012, baseline data from the Global Appraisal of Individual Needs (GAIN) were summarized for 159 participants in Strategy 5a. Prior to any SUD treatment, only 12 of these JJAT youth (8%) had not used marijuana in the past 90 days, compared to 49 youth (31%) who had not used alcohol.

A follow-up GAIN analysis in February 2014 found that the average number of days in the past 90 with marijuana use fell from 40 (Pre) to 33 (Post). For youth who used alcohol, 57 percent of them reduced their frequency of alcohol use over time.

Detention Use: Of 299 JJAT youth eligible for fifth post outcomes by time alone, 217 (73%) were detained. Detention bookings for this group were reduced from 536 (Pre) to 287 (Post 5), nearly meeting the targeted goal of reducing youth detentions by 50 percent over five years (See Page 8).

Treatment Linkage: Within one year of their first JJAT contact, 345 of 2,049 youth (17%) were linked with mental health benefits paid via public funding. Similarly, 368 youth (18%) had confirmed linkages to SUD treatment.

* During Year 7, the coordination target was adjusted due to: 1) multiple staff turnovers (including a six-month vacancy in the position conducting short screeners), 2) the amount of time needed to onboard new staff, and 3) the fact that juvenile filings were down over five percent from January to September 2015 compared to a year ago, resulting in fewer arraignments and fewer assessments.

Wraparound is an evidence-based practice that coordinates both formal and informal supports for youth with serious emotional/behavioral disorders. The wraparound process customizes care for high-need youth throughout King County, focusing on their individual and/or family strengths and cultural factors. Teams at five community treatment agencies work collaboratively within their communities to surround all youth they serve with support and a package of services that addresses their unique needs and goals.

Primary Policy Goals: Divert youth from justice system involvement and reduce detentions

Secondary Policy Goal: Reduce incidence and severity of mental illness symptoms

		Annual or Adjusted Targets and Performance Measurement							
Measure	Revised Target		Year 1 2008-9	Year 2 2009-10	Year 3 2010-11	Year 4 2011-12	Year 5 2012-13	Year 6 2013-14	Year 7 2014-15
Number of Enrolled Youth	450	Target	0	920	374	450	450	450	450
		Actual	0	282	414	520	635	593	558
		Percent	N/A	31%	111%	116%	141%	132%	124%

Target Adjustments and Notes: Year 2 (enrolled youth plus their siblings); Year 3 (staff vacancies)
Only enrolled youth could be counted, so target was revised in 2010.

Strategy 6a Key Findings Summary

Detention Use: Only 25 percent of youth in Wraparound had any detention bookings. The number of days these youth were detained increased in all post periods, except the fifth (slight decline of -4%).

Other Outcomes: Evidence of the effectiveness of this strategy to meet other MIDD goals were published previously:

August 2013: An independent analysis by the King County Children's Mental Health Planner showed improved behavior, rule compliance, and school performance for 159 youth with multiple scores.

February 2015: Behavioral information was available for 638 youth with service starts before April 2014. Property damage and harm to others were both reduced markedly over time, while compliance with household rules increased significantly. At one year after initial assessment, 42 percent of caregivers felt youth behavior had improved, compared to only 28 percent surveyed at the six-month mark. Caregivers reported reductions in perceived problem severity across 21 items measured, such as worry, sadness and caregiver strain.

Independent Fidelity Review Pinpointed Strengths and Areas to Improve

Results of the University of Washington's fidelity review for MIDD Wraparound programs were made available in January 2015. Key strengths identified were:

- Linking families to community resources
- Involving caregivers in the child/family team
- Celebrating family successes.

Two areas for further development included: 1) increasing efforts to inform and engage families at the start, and 2) helping families build skills for success after exit.

Independent Outcomes Evaluation Highlighted Program Successes

Reports completed by Wraparound Evaluation & Research Team found that as a result of MIDD Wraparound:

- Full-time school enrollment increased
- School suspensions decreased
- Emergency room use decreased
- Fewer youth used substances
- Fewer youth were arrested.



Expansion of Children's Crisis Outreach Response System (CCORS) **7b**

Youth crisis services were expanded in 2011 to address increased demand and to augment staffing with in-home behavioral support specialists. The CCORS team provides direct assistance to families in order to maintain troubled youth safely in their own homes and communities. The MIDD also partially supports marketing and communication efforts for the purpose of increasing awareness about CCORS services. Brochures and posters are available to the public in four languages: English, Spanish, Somali and Vietnamese.

Primary Policy Goal: Reduce jail, emergency room and psychiatric hospital use

Secondary Policy Goal: Divert youth from justice system involvement

		Annual or Adjusted Targets and Performance Measurement							
Measure	Original Target		Year 1 2008-9	Year 2 2009-10	Year 3 2010-11	Year 4 2011-12	Year 5 2012-13	Year 6 2013-14	Year 7 2014-15
Number of Enrolled Youth	300	Target	0	0	0	300	300	300	300
		Actual	0	0	0	951	959	1,030	1,043
		Percent	N/A	N/A	N/A	317%	320%	343%	348%

Target Adjustments and Notes: Blended funds allowed more youth to be served than MIDD funds alone.

Strategy 7b Key Findings Summary

Detention Use: Of 2,710 CCORS youth eligible for first year outcomes, only 298 (11%) had juvenile justice detentions. The total number of both detention bookings and days increased greatly for this group between the pre and first post period. By the third post analysis, the observed increases in detention use were less dramatic as shown on Page 65. Due to the late start for this strategy, longer term data are not yet available to show any reductions.

Emergency Department (ED) Use: Admissions for CCORS youth to Harborview's ED decreased in the second post period by 28 percent, but increased in both the first and third post periods by as much as 14 percent. Admissions to EDs other than Harborview during the first year after their MIDD start date were studied for 487 youth. The total number of admissions at these other hospitals rose from 140 (Pre) to 243 (Post 1), a 74 percent increase. Detailed results of this analysis appear on Page 67.

Psychiatric Hospital Use: Fewer than 10 percent of outcomes-eligible youth had any psychiatric hospitalizations. After increases in admissions and days during the first post period, admissions declined by 13 percent in the second post, and by 33 percent in the third. The total number of days psychiatrically hospitalized increased in all post periods for those youth who received community inpatient psychiatric services.

Many Youth in Crisis Were Diverted from Hospitalization and Achieved Housing Stability

Detailed information was provided for 4,382 unique cases since MIDD funding of CCORS began. Of the 3,599 cases with direct services, outreach was provided for 35 percent, and crisis stabilization was provided for the remainder.

Where hospital diversion was listed as the referral reason (N=1,504), 68 percent of youth were diverted from hospitals, 20 percent were voluntarily hospitalized, and only 12 percent were involuntarily hospitalized.

Where the residential arrangement upon exit from services was known (N=2,232), 81 percent of youth remained in their homes and five percent returned home from other living arrangements.



When parental substance abuse results in removal of children from their homes by the state, Family Treatment Court (FTC) provides an opportunity for families to reunite. Enrolled individuals are closely monitored by this specialized therapeutic court throughout their substance use disorder (SUD) recovery, with the goal of minimizing their children's involvement in the child welfare system.

Primary Policy Goals: Reduce jail recycling and incidence and severity of SUD symptoms

		Annual or Adjusted Targets and Performance Measurement							
Measure	Revised Target		Year 1 2008-9	Year 2 2009-10	Year 3 2010-11	Year 4 2011-12	Year 5 2012-13	Year 6 2013-14	Year 7 2014-15
Number of Children in Families Served	90	Target	34	45	90	90	90	90	120
		Actual	27	48	83	103	90	93	103
		Percent	79%	107%	92%	114%	100%	103%	86%

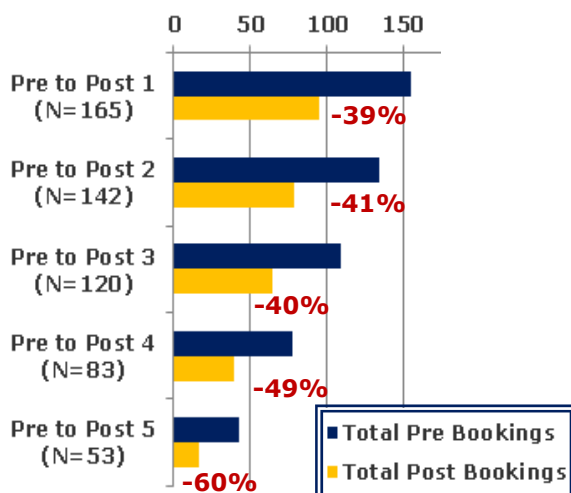
Target Adjustments and Notes: Year 1 (9 months); Years 1 & 2 Target = 45 (adjusted in 2011 due to budget proviso) Cap was lifted in Year 7 to allow 120 children per year, not to exceed 60 at any one time (FTC monitors capacity).

Strategy 8a Key Findings Summary

Using data provided by the court, 172 clients out of 193 (89%) were admitted to SUD treatment. About half enrolled in outpatient treatment, while the other half had both inpatient and outpatient care.

Jail Use: At least half of all participants in FTC had jail use other than the events that led to their enrollment in this therapeutic court. In all post periods, jail bookings declined over time as shown in the graphic below. The greatest reduction in the total number of days jailed (not shown) was 51 percent, recorded in the fifth post period.

Jail Bookings Ultimately Reduced by 60 Percent



Symptoms: As reported in August 2015, 139 adults in FTC were time eligible for substance use reduction outcomes. Information on SUD treatment admissions was matched to 86 of these people, the majority of whom were female (82%). The primary substance used by the most people was methamphetamine (27%), followed by cocaine and alcohol at 20 percent each.

Periodic milestone data, or information gathered at six-month intervals on changes in substance use over time, was available for 49 people. Thirty individuals (61%) reported no substance use in the 30 days before outpatient treatment began and had no change in use over time. Seventeen of the remaining 19 who said they did use substances (79%) decreased their use between admission and the first milestone time point.

For those without milestone data, changes were assessed using only admission and discharge data. Sixteen of the 36 people who reported using a substance in the month before treatment (44%) showed less use by their discharge time point.

The overall percentage of FTC clients with any outcomes data who reduced their substance use to zero (abstinence) or stayed use free over time was 78 percent.

Juvenile Drug Court (JDC) expansion under the MIDD has allowed more youth living in the south region of King County to receive therapeutic court services, often in lieu of incarceration. The MIDD funded five additional positions: four specialized juvenile probation counselors and one treatment liaison. The court offers weekly hearings and introduces youth to substance use disorder (SUD) treatment through a number of different engagement track options.

Primary Policy Goals: Divert youth from justice system involvement and reduce SUD symptoms

		Annual or Adjusted Targets and Performance Measurement							
Measure	Original Target		Year 1 2008-9	Year 2 2009-10	Year 3 2010-11	Year 4 2011-12	Year 5 2012-13	Year 6 2013-14	Year 7 2014-15
Number of New Youth	36 with 5.5 FTE	Target	27	33	36	36	36	36	36
		Actual	29	41	26	50	84	76	89
		Percent	107%	124%	72%	139%	233%	211%	247%

Target Adjustments and Notes: Year 1 (9 months); Year 2 (5 FTE); Years 1 to 3 Target = opt-ins only
Program was re-designed in 2011 due to declining referrals—new tracks were offered and all youth were counted.

Strategy 9a Key Findings Summary

Detention Use: The best detention use outcomes were found in the fourth post period for JDC youth. Of the 93 youth enrolled prior to July 2011, 77 (83%) had one or more detention bookings in either the year before their MIDD start or in the fourth year after. Their total number of detention bookings fell by 48 percent, from 212 to 110. The total number of days detained, however, decreased by only 12 percent (from 2,622 to 2,311 days) over that same time period. With larger samples over time, the results are expected to improve.

All JDC Graduates Were Successfully Admitted to SUD Treatment

A total of 217 youth exited from MIDD-funded JDC services prior to September 2015. Of those, 106 (49%) had either successfully completed their engagement track or had graduated from the program after opting in. The remaining 111 (51%) opted out before completion, were terminated from the program or left early for other reasons.

For program graduates, the SUD treatment enrollment rate was 100 percent, compared to only 77 percent for those who completed the engagement track. The enrollment rate for youth who left the program before completing a track was also very high, at 93 percent.

Treatment Linkage: Enrollment in publicly-funded SUD treatment within a year of their MIDD service starts was confirmed for about half of all JDC youth. Since the overall SUD treatment enrollment rate as reported by the court was over 80 percent, it is likely that some JDC youth had access to private sector treatment through parental insurance.

Symptoms: Substance use symptom reduction was studied in February 2014 for six males enrolled in JDC. When combined with youth from other MIDD strategies, including 139 who participated in Strategy 5a - Juvenile Justice Youth Assessments, it was found that marijuana was the drug used most often. In the combined study sample, average days without any drug or alcohol use in the past 90 days rose from 50 to 60 (a 20% increase in "clean" days). The total number of youth reporting abstinence from substances rose from 22 to 60, a 173 percent increase. The very small number of youth in the "JDC only" sample precludes reporting of their results separately, but it should be noted that there is a great deal of overlap between youth strategies. In the current period, half of all JDC youth had also been served by the assessment team.



Domestic Violence Prevention

13b

In collaboration with two domestic violence (DV) agencies, Sound Mental Health operates the Children's Domestic Violence Response Team (CDVRT), whose goal is reducing the severity of DV-related trauma effects on children and non-abusive parents. The availability of CDVRT services in the south region of the county has been greatly enhanced because of the MIDD. The CDVRT integrates mental health (MH) treatment with effective DV prevention/intervention practice.

Primary Policy Goals: Reduce incidence and severity of mental illness symptoms

Secondary Policy Goal: Link with other Council-directed initiatives

		Annual or Adjusted Targets and Performance Measurement							
Measure	Original Target		Year 1 2008-9	Year 2 2009-10	Year 3 2010-11	Year 4 2011-12	Year 5 2012-13	Year 6 2013-14	Year 7 2014-15
Number of Unique Families	85	Target	78	85	85	85	85	85	85
		Actual	102	144	134	147	135	144	155
		Percent	131%	169%	158%	173%	159%	169%	182%

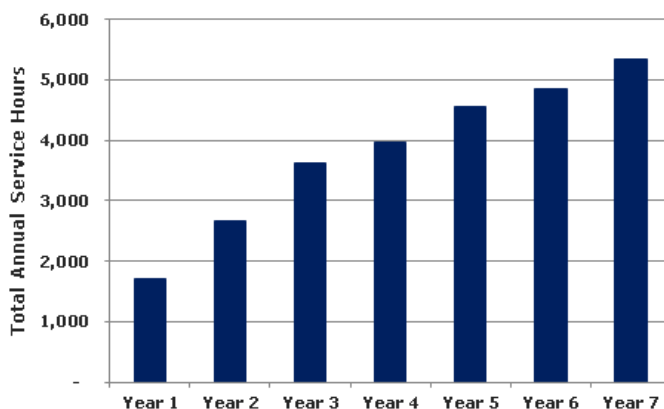
Target Adjustments and Notes: Year 1 (11 months)

Strategy 13b Key Findings Summary

Initiative Linkage: King County's commitment to creating safe communities is evident in strategic planning efforts, informed partly by a countywide needs assessment of infants, children and youth exposed to DV. The Safe and Bright Futures for Children Initiative (2004) explored the needs of this vulnerable population and recommended formulation of the CDVRT to mitigate the impacts of DV on children. In 2008, the MIDD furthered this aim by funding a second team whose geographic focus area was south King County. More recently, King County's 2014 Youth Action Plan (Ordinance 17738) reiterated the need to invest in prevention resources for youth exposed to adverse childhood experiences.

Total service hours delivered to CDVRT-South families increased each year since the MIDD began, as shown.

Total Service Hours Increased Year After Year



Symptoms: As reported in February 2012, a Pediatric Symptom Checklist (PSC-17) is used to screen children for CDVRT services. This instrument rates levels of internalizing, externalizing and attentional behaviors with a maximum score of 34. Total scale scores over 14 are considered above the clinical threshold, and about half of all children had screened above this level, indicating problems exist.

In 2013, an analysis of symptom reduction was completed using 97 cases with PSC-17 measures taken at least two months apart. Scores dropped below the threshold of concern for 43 children (44%) at some point during their treatment. Those who reduced symptoms were in treatment on average for 17 months versus only 14 months for those remaining at elevated symptom levels.

A recent study of 253 unique children with at least one PSC-17 measure after treatment began showed that 116 (46%) scored below the clinical threshold at some point during treatment.

Jail and Hospital Diversion Strategies

Moral Reconciliation Therapy (MRT) Really Does Work

L knows from experience that MRT works. Not only did he successfully complete the MRT program himself, but he now facilitates MRT groups and watches proudly as others succeed.

Raised in Texas during the 1960s, L spent more of his life incarcerated than free. Growing up, he saw many atrocities against African Americans, such as people being nailed to trees, having their skin burned off, and even hangings, including his own uncle. Seeing members of his community victimized, he developed hatred for and distrust of white people.

He first went to jail for stealing a bicycle when he was six years old and refusing to tell the cops who his parents were. They put him in an adult jail. From there, L continued to get in trouble and ended up in the State School for Boys where he was physically abused and sexually assaulted by the guards who were supposed to protect him. He became "hardened, only fit for incarceration" and quickly ended up back in jail after each release. He developed an institutionalized way of looking at life. Suffering from depression, there was no place for compassion in prison. He sat with his back to the wall and protected himself. Trust was not an option. He developed the view that all people lie, cheat and steal.

After relocating to the Seattle area, L continued to be in and out of both jail and prison. He went through MRT four times before he reached a point in his life when he really tried to apply the principles to his life. Where previously he fell back into a pattern of dishonesty, he realized that he had to be honest in order to build trust with people. Caught in the cycle of our criminal justice system, battling mental health and substance use issues, he slowly began to "accept life on life's terms" with help from Community Center for Alternative Programs (CCAP), Adult Drug Court, MRT and South Seattle Community College.



Story and Photo by Kimberly Cisson

Strategy 12d

Behavior
Modification
Classes



L said, "If I can change MY life, just think of how many lives can be changed!" Hope is essential, and "MRT gives you an opportunity to truly look at yourself." He is currently lobbying for people involved in the criminal justice system, especially around housing and life skills. Applying MRT principles to his own life, he encourages others to make similar changes, all while completing classes to become a chemical dependency counselor.

Agencies Providing MIDD Diversion Services	Type	10a	10b	11a	11b	12a	12b	12c	12d	15a	16a	17a	17b
Catholic Community Services	MH & SUD										X		
City of Seattle	Partner				X								X
Community House	MH										X		
DESC	MH & SUD		X								X		
Harborview	MH & SUD						X	X					
KC Department of Adult & Juvenile Detention (+)	Partner					X			X				
King County Judicial Administration (+)	Partner									X			
Plymouth Housing Group	MIDD										X		
Public Health (+)	Partner						X						
Sound Mental Health (+)	MH & SUD			X	X	X			X		X		
Transitional Resources	MIDD										X		
Valley Cities Counseling & Consultation	MH & SUD										X		
WA State Criminal Justice Training Commission	Partner	X											

(+) = Subcontractors also receive MIDD funding through these agencies.

Non-MIDD funding secured

Crisis Intervention Team (CIT) Training for First Responders

10a

Specialized trainings introduce law enforcement officers and other first responders to concepts, skills and resources that can assist them when responding to calls involving people with mental illness or substance use disorders. Delivered at the Washington State Criminal Justice Training Commission in partnership with the King County Sheriff's Office, CIT trainings focus on diverting people to appropriate services while maintaining public safety. Funds also reimburse agencies, as needed, for backfill when officers are in training.

Primary Policy Goal: Link with other Council-directed initiatives

Measure	Revised Target	Annual or Adjusted Targets and Performance Measurement							
			Year 1 2008-9	Year 2 2009-10	Year 3 2010-11	Year 4 2011-12	Year 5 2012-13	Year 6 2013-14	Year 7 2014-15
Number of 40-Hour Trainees	180	Target	0	0	375	180	180	180	180
		Actual	0	0	275	256	251	200	199
		Percent	N/A	N/A	73%	142%	139%	111%	111%
Number of One-Day Trainees	300	Target	0	0	1,000	300	300	300	300
		Actual	0	0	626	266	268	657	553
		Percent	N/A	N/A	63%	89%	89%	219%	184%
Number of Other Trainees	150	Target	0	0	0	150	150	150	150
		Actual	0	0	0	185	163	159	312
		Percent	N/A	N/A	N/A	123%	109%	106%	208%

Target Adjustments and Notes: Year 3 Targets = 375 40-hour and 1,000 one-day trainees were too high. In Years 6 & 7, accommodations were made in order to train all Seattle Police Department officers in CIT.

Strategy 10a Key Findings Summary

Initiative Linkage: King County's Adult & Juvenile Justice Operational Master Plans (2000 and 2002) support collaborative work across partners "to ensure that the criminal justice system is fair, effective, efficient, and integrated." Making better use of alternatives to incarceration is a primary focus these initiatives. A review of Seattle Police Department data in 2015 found that arrests and use of force were very rare for people who were in drug-induced or mental health crises, due largely to enhanced CIT training and the deployment of trained officers.

Both Course Feedback and Independent Evaluations Support Program Effectiveness

Since CIT trainings began in October 2010, trainees have been asked to evaluate their learning experiences. The two classes with the highest "excellent" ratings over time (above 75%) were Excited Delirium and Communicating with Persons with Mental Illness/De-Escalation Techniques. Evaluation results are used to continuously improve the relevance and usefulness of all courses.

In 2012 and 2013, two external consulting firms evaluated the CIT training program. Identified strengths included availability to many agencies, quality control procedures, strong instructors and adherence to the CIT curriculum model. Suggested improvements included reviewing course learning objectives, building on topics in systematic order and grouping the resource topics into a panel with a question-and-answer format. Mock scenarios reinforced proficiency in CIT principles.

In June 2015, Seattle University's Department of Criminal Justice published findings on the effect of CIT curriculum changes on officer attitudes and knowledge. Using pre/post surveys, the researchers showed clear training effects with respect to support for CIT and broad cultural support for the CIT model. Every officer surveyed felt that CIT training was helpful and many wanted more training.

Adult Crisis Diversion Center, Respite Beds, and Mobile Behavioral Health Crisis Team

10b

Strategy 10b relies on three interconnected programs operated by DESC through the Crisis Solutions Center (CSC) that opened in August 2012. The programs include: 1) a Mobile Crisis Team responding to first responder requests for crisis de-escalation; 2) a facility specializing in short-term stabilization for adults in crisis; and 3) an interim services facility with up to two weeks of further services to address individualized needs after initial crisis resolution.

Primary Policy Goals: Divert from and reduce jail, emergency room and psychiatric hospital use

		Annual or Adjusted Targets and Performance Measurement							
Measure	Original Target		Year 1 2008-9	Year 2 2009-10	Year 3 2010-11	Year 4 2011-12	Year 5 2012-13	Year 6 2013-14	Year 7 2014-15
Number of Clients	3,000	Target	0	0	0	500	3,000	3,000	3,000
		Actual	0	0	0	359	2,353	2,905	3,352
		Percent	N/A	N/A	N/A	72%	78%	97%	112%

Target Adjustments and Notes: Year 1 (2 months)

Individuals are counted once for participation in each of the three different program components.

Strategy 10b Key Findings Summary

Jail Use: Delayed implementation of Strategy 10b has impacted the availability of long-term outcomes data. Of the CSC clients eligible for a third post analysis, jail bookings were reduced from a total of 184 to 140 (-24%). Days incarcerated, however, rose from 3,024 (Pre) to 3,427 (Post 3), an increase of 13 percent. Neither change was statistically significant.

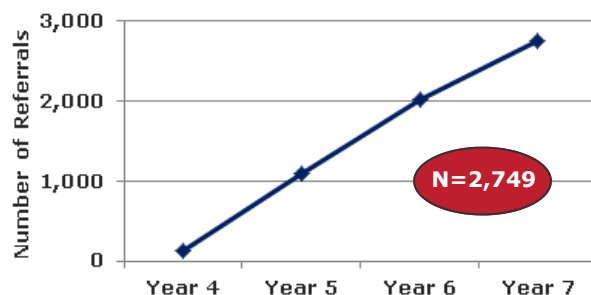
Emergency Department (ED) Use:

First-year increases in the use of the ED at Harborview were calculated at 51 percent. At other area EDs, the increase was found to be 22 percent. By the third year post period, admissions at Harborview were reduced by 28 percent.

Psychiatric Hospital Use: Psychiatric hospitalizations, including stays at Western State Hospital, decreased slightly (-5% in Post 2) and (-8% in Post 3), after increasing by 87 percent in the first post period. The total number of days housed in inpatient psychiatric care settings increased in all post periods when compared to the number of psychiatric hospital days in the year prior to each person's first CSC intake.

Other Outcomes: Two indicators of system-level performance were examined with data available from November 2011 to August 2015. The total number of referrals to behavioral health treatment increased over time as shown in the graphic below. Note that multiple referrals per person were possible, but more than a single referral per CSC admission was rare.

Nearly 3,000 Treatment Referrals Made



Documented diversions from area hospitals were common (nearly 4,500 over four years), while jail diversions were fairly rare (262 over that period). The provider could record only one diversion per admission to the CSC, so it is possible that jail diversions were underreported in the data. The greatest number of total diversions was recorded in MIDD Year Five at 1,739.

Strategy 11a**Increase Jail Liaison Capacity****11a**

During court proceedings, judges occasionally assigned individuals to King County Work and Education Release (WER), a program where clients can go to work, school or treatment during the day and return to a secure facility at night. Liaison services were available to WER participants prior to completion of their court-ordered time. The liaison's job involved linking clients to services and resources, such as housing and transportation, to reduce recidivism risks. In 2014, the capacity at WER was reduced from 160 to 79, so the work of the liaison was expanded to serve additional criminal justice system populations.

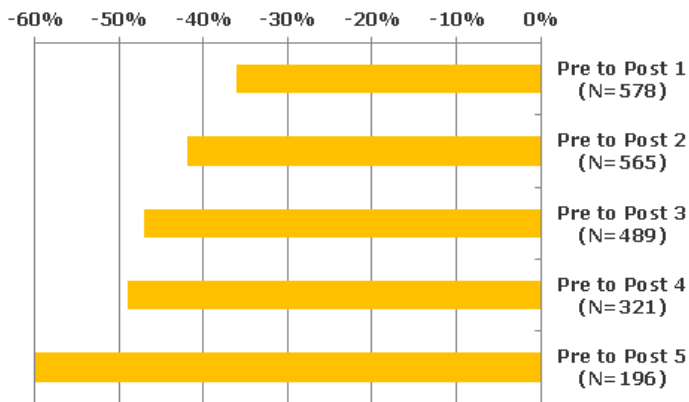
Primary Policy Goal: Reduce jail recycling for clients with mental illness or SUD

		Annual or Adjusted Targets and Performance Measurement							
Measure	Revised Target		Year 1 2008-9	Year 2 2009-10	Year 3 2010-11	Year 4 2011-12	Year 5 2012-13	Year 6 2013-14	Year 7 2014-15
Number of Clients	200	Target	270	200	200	200	100	50	100
		Actual	116	279	195	192	69	13	35
		Percent	43%	140%	98%	96%	69%	26%	35%

Target Adjustments and Notes: Year 1 (9 months); Years 5 & 6 (staff vacancies); Year 7 (reduced capacity) Year 1 Target = 360 (The initial target was based on previous liaison figures, but referrals were lower than expected.) A new target was not set for MIDD Year 8, as program continues to adapt to try to reach its adjusted target.

Strategy 11a Key Findings Summary

Jail Use: Eight of ten Strategy 11a clients had jail utilization beyond the booking episode associated with their start of MIDD liaison services. The total number of jail bookings was reduced in all five post periods as shown below. The greatest reduction in aggregate jail days (not shown) was in the fifth post period (-29%).

Liaison Services Paired With Fewer Jail Bookings

Treatment Linkage: Of the 700 WER liaison clients who were eligible for analysis of first post outcomes, about one in four was linked with public sector behavioral health treatment within one year of their MIDD start date.

Treatment linkage rates varied by demographic variables. For example, clients linked to treatment were four years older, on average, than those not linked. Caucasians were linked to mental health treatment at a much lower rate (21%) than other ethnic groups, such as African American or Black (31%), Asian/Pacific Islander (32%) and Native American (42%). Those of Hispanic origin were more likely to be linked to SUD treatment (35%) than non-Hispanics (22%).

In a sample of 311 WER liaison clients, 57 (18%) were permanently housed at exit from services and 121 (39%) had temporary or transitional housing. The portion released to institutions was 20 percent and the remaining 23 percent experienced homelessness.



Increase Services for New or Existing Mental Health Court Programs

11b

King County District Court's Regional Mental Health Court (RMHC) began accepting referrals from 39 municipalities throughout the county in 2010. The MIDD provided funding for nine staff, including a dedicated judge, prosecution and defense attorneys, probation officers, court staff and liaisons to manage these additional cases. Strategy 11b has expanded over time to provide: 1) a court liaison for the Municipal Court of Seattle's Mental Health Court (SMHC) that handles legal competency cases for people booked into jail on charges originating in the City of Seattle; 2) forensic peer support for opt-ins to RMHC; and 3) a Veteran's Track piloted and now operating within the existing RMHC.

Primary Policy Goal: Divert clients with mental illness from justice system involvement

Secondary Policy Goal: Reduce incidence or severity of mental illness symptoms

		Annual or Adjusted Targets and Performance Measurement							
Measure	Revised Target		Year 1 2008-9	Year 2 2009-10	Year 3 2010-11	Year 4 2011-12	Year 5 2012-13	Year 6 2013-14	Year 7 2014-15
Number of RMHC Opt-In Clients	28 expansion cases	Target	0	44	57	38	57	28*	28
		Actual	0	26	31	22	53	44	28
		Percent	N/A	59%	54%	58%	93%	157%	100%
Number of SMHC Clients Screened	300	Target	0	0	0	50	300	300	300
		Actual	0	0	0	268	318	303*	287
		Percent	N/A	N/A	N/A	536%	106%	101%	96%

Target Adjustments and Notes: Year 2 (startup); Year 4 (staff vacancies); Years 2 to 5 Target = 57 expansion opt-ins RMHC underwent several revisions, including adding a target of 83 RMHC non-expansion cases in 2013 (not shown above). Year 4 Target = 50 SMHC clients who were not competent to stand trial

* Corrections to previously reported information were made here.

Strategy 11b Key Findings Summary

Expansion cases for RMHC are those opting in after referral from cities throughout King County. In MIDD Year Six, when funding switched from supplantation to core MIDD for all therapeutic courts, tracking of the non-expansion cases was added, including felony drop downs and misdemeanors, as shown on Page 56. Over 40 veterans were among those served this period by RMHC.

SMHC Independently Evaluated in 2013

Law and Policy Associates reported that only 24 percent of clients who successfully completed SMHC had any jail bookings in the two years afterwards, compared to 95 percent of those who failed to finish. Even non-completers increased their use of mental health services, however, and lowered jail use rates after participating in court supervision. The MIDD funds one court liaison position for SMHC.

Jail use: Deep reductions in jail bookings were found for both SMHC clients (-64% in Post 3) and RMHC clients (-57% in Post 4). The total number of jail days fell at less dramatic rates, with the maximum reduction coming for RMHC participants in the fourth post period (-22%).

Symptoms: About half of all RMHC and SMHC clients were linked to publicly-funded mental health treatment within a year of their service start. For a sample of 472 people who had anxiety and depression scores at two different points in time, it was found that 74 percent stayed stable over time. For remaining cases where change could be measured, 104 of 124 people with anxiety scores (84%) improved at some point during treatment. For depression, the improvement rate was 83 percent.



Short-term case management services are provided to incarcerated individuals with mental health (MH) issues and/or substance use disorders (SUD) who are near their release date. Originally expanded through the MIDD to serve more people jailed in the county's south and east regions, MIDD now funds the base program, as previously available state funding was cut. Community reintegration and reduced recidivism are the primary goals of the jail re-entry program.

Primary Policy Goal: Reduce jail recycling for clients with mental illness or SUD

		Annual or Adjusted Targets and Performance Measurement							
Measure	Revised Target		Year 1 2008-9	Year 2 2009-10	Year 3 2010-11	Year 4 2011-12	Year 5 2012-13	Year 6 2013-14	Year 7 2014-15
Number of Clients	300 with 3 FTE	Target	480	200	250	300	300	300	300
		Actual	297	258	260	258	213	213	214
		Percent	62%	129%	104%	86%	71%	71%	71%

Target Adjustments and Notes: Year 1 (split with 12a-2); Year 2 (2 FTE); Year 3 (2.5 FTE)

Year 1 Target = 1,440 for all 12a combined

A new target was not set for MIDD Year 8, as program continues to adapt to try to reach its adjusted target.

Strategy 12a-1 Key Findings Summary

Jail Use: The number of clients eligible for fifth post outcomes in this strategy was 423. Of those, 364 (86%) had at least one jail booking unrelated to the one that connected them with MIDD services. Jail bookings were reduced for this group by 66 percent, from 1,220 (Pre) to 418 (Post 5). Total days in jail were reduced by 67 percent, from 30,928 (Pre) to 10,177 (Post 5). These long-term reduction rates are expected to improve even further as the size of the outcomes-eligible sample grows over time.

Treatment Linkages: Confirmed linkages to behavioral health treatment were studied for 1,100 people eligible for first post outcomes. Within a year of their MIDD service start, 412 clients (37%) began MH services and 362 (33%) were enrolled in treatment for substance issues. Individuals linked to treatment did not differ by race, Hispanic origin, or veteran status from those who were not linked.

Housing: In a sample of 516 jail re-entry clients with data on housing status at exit, the number of people permanently housed was 80 (16%). Another 162 had temporary or transitional housing (31%), while the rest experienced either homelessness (42%) or further institutionalization (11%). The rate of homelessness was much higher for this strategy than for Strategy 11a (at 23%).

King County Criminal Justice Initiative (CJI) Provided Overarching Vision for Re-Entry

The CJI was launched in 2003 to reduce long-term jail utilization by implementing ten programs that provided housing, MH and SUD services, and assistance for people involved with the local criminal justice system. The state legislature then implemented Jail Transitions Services in 2005, providing additional financial backing for CJI services. Adoption of the MIDD Plan in 2007 called for expanding these types of services to adults exiting King County jails, especially in the county's south and east regions. With the economic downturn of 2008, state funding for re-entry services became scarce and local MIDD funding was essential in filling the gaps and preserving the continuity of comprehensive, recovery-centered services. Programs under the CJI umbrella were rigorously evaluated and evidence of their effectiveness is available on the county website.



Education Classes at Community Center for Alternative Programs (CCAP)

12a-2

Adults in the criminal justice system may be court-ordered to serve time at CCAP and/or The Learning Center (TLC). King County's Community Corrections Division holds people accountable for attendance in various structured programs, including those made possible at CCAP and TLC. With MIDD funding, life-skills, job and general education (GED) preparation, and domestic violence (DV) prevention classes are provided. All courses seek to reduce the risk of re-offense.

Primary Policy Goal: Reduce jail recycling for clients with mental illness or SUD

		Annual or Adjusted Targets and Performance Measurement							
Measure	Revised Target		Year 1 2008-9	Year 2 2009-10	Year 3 2010-11	Year 4 2011-12	Year 5 2012-13	Year 6 2013-14	Year 7 2014-15
Number of Clients	600	Target	960	600	600	600	600	600	600
		Actual	114	449	545	579	520	590	532
		Percent	12%	75%	91%	97%	87%	98%	87%

Target Adjustments and Notes: Year 1 (split with 12a-1); Year 1 Target = 1,440 for all 12a combined
Individuals are counted once for participation in each different program component.

Strategy 12a-2 Key Findings Summary

Strategy 12a-2a: The Learning Center

Jail Use: In the fifth post period, aggregate jail bookings went down by 57 percent and the associated days in jail were reduced by 50 percent. For this sample of 152 people with jail bookings beyond those related to MIDD start dates, 54 percent had taken Life-Skills-to-Work (LSW) classes, while 46 percent took GED. Slightly more LSW students reduced their jail days (79%) over this long term than GED students (73%), but the difference was not statistically significant.

Overall, more males (83%) engaged in LSW or GED education opportunities than females (17%), but long-term jail use reductions were equally evident for both gender groups.

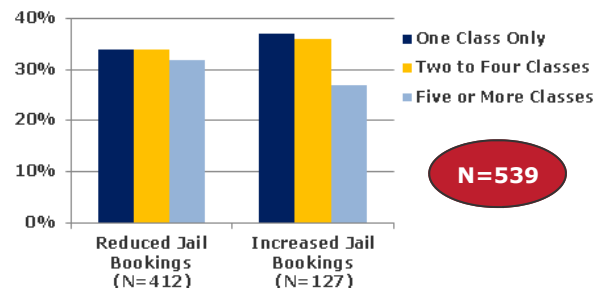
In late 2014, South Seattle College released outcomes for CCAP students enrolled in TLC programs. Of 1,492 in LSW, 435 (29%) had completed the program as of 9/27/2014. For GED, 205 of 1,131 (18%) received an equivalency certificate. These results included individuals enrolled prior to availability of MIDD funding.

Strategy 12a-2b: DV Classes at CCAP

Jail Use: Like those who took education classes at TLC, individuals taking DV courses at CCAP also reduced their jail use over the long range. By the fifth post period, bookings were down by 62 percent and the total number of days recorded for the 269 people who began services prior to July 2010 was reduced from 7,352 to 4,730 (-36%).

An analysis to examine the relationship between the number of DV courses taken and jail use change over time used data from the third post period. As shown below, reduced jail bookings did not appear to be dependent on the number of classes taken. For students whose bookings increased, however, a slightly higher percentage had taken only one class, as opposed to five or more classes.

Class Attendance Differences by Jail Use Changes



Strategy 12b



Hospital Re-Entry Respite Beds (Recuperative Care)

12b

The September 2011 opening of an expanded medical respite program adjacent to Seattle's Harborview Medical Center (HMC) was made possible with funds from over 10 different sources, including the MIDD. The program serves adults without housing who need a safe place to recuperate upon discharge from area hospitals. The MIDD helps provide mental health (MH) and substance use disorder (SUD) services, including case management, treatment referrals and housing linkages.

Primary Policy Goal: Reduce jail, emergency room and psychiatric hospital use

		Annual or Adjusted Targets and Performance Measurement							
Measure	Original Target		Year 1 2008-9	Year 2 2009-10	Year 3 2010-11	Year 4 2011-12	Year 5 2012-13	Year 6 2013-14	Year 7 2014-15
Number of Clients	350-500	Target	0	0	29	350	350	350	350
		Actual	0	0	26	342	395	334	366
		Percent	N/A	N/A	90%	98%	113%	95%	105%

Target Adjustments and Notes: Year 3 (1 month)

Strategy 12b Key Findings Summary

Jail Use: Delayed implementation of this strategy means that outcomes information for strategy participants is only available through the third post period. Total jail bookings were reduced from 231 (Pre) to 141 (Post 3), a 39 percent reduction. Aggregate jail days remained steady at 3,290 over this analysis period, as longer sentences were received in the third post period.

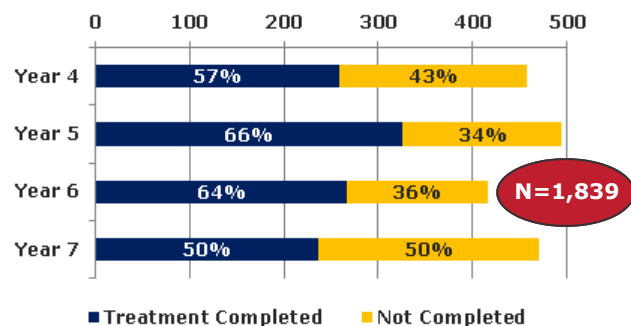
Emergency Department (ED) Use:

Total admissions to the ED at Harborview fell from 842 to 586 (-30%) by the third post period, overcoming increases of 47 percent in the first year post. Using a new data source, first year Harborview increases were confirmed, accompanied by reductions (-9%) at other area EDs.

Psychiatric Hospital Use: Only about nine percent of the people who used the medical respite program had any psychiatric hospitalizations over the various outcomes study periods. In the third post period, total admissions were reduced from 36 to 11 (-69%), but the total number of days hospitalized at Western State Hospital or at inpatient psychiatric hospitals in the community rose from 340 to 441 (+30%).

Other Outcomes: Using exit data since medical respite was expanded, treatment completions varied slightly year to year, as shown below. Of the 1,087 patients who successfully completed treatment, 727 (67%) were sheltered, transitionally housed or permanently housed at exit.

Program Completions Outpaced Early Exits



Respite Program Earns Innovation Grant

The Centers for Medicare & Medicaid Services chose the medical respite program as a 2014 recipient of an innovation grant award. The goal of this grant is to improve health, reduce readmissions and reduce costs. The program will track patients receiving respite services in an effort to decrease hospital readmissions by 20 percent and to reduce the length of hospital stays by 30 percent.





Increase Harborview's Psychiatric Emergency Services (PES) Capacity

12c

For Strategy 12c, intensive case managers use assertive techniques to engage reluctant clients who have been identified as high-utilizers of Harborview Medical Center's emergency department (ED). By developing therapeutic relationships during outreach efforts and while assisting with medically-centered services, social workers work together with people experiencing homelessness to find solutions to problems that formerly presented insurmountable barriers to their successful investment in more traditional systems of care.

Primary Policy Goal: Reduce jail, emergency room and psychiatric hospital use

		Annual or Adjusted Targets and Performance Measurement							
Measure	Original Target		Year 1 2008-9	Year 2 2009-10	Year 3 2010-11	Year 4 2011-12	Year 5 2012-13	Year 6 2013-14	Year 7 2014-15
Number of Clients	75-100	Target	69	75	75	75	75	75	75
		Actual	87	175	111	77	104	86	81
		Percent	126%	233%	148%	103%	139%	115%	108%

Target Adjustments and Notes: Year 1 (11 months)

Strategy 12c Key Findings Summary

Jail Use: Reductions in jail bookings for PES clients were evident for each post period studied, with the greatest drop (-65%) calculated in Post 5. The maximum reduction in jail days was 34 percent (Post 4).

Emergency Department (ED) Use:

Harborview ED admissions fell from a total of 2,517 (Pre) to 809 (Post 5), a long-term reduction of 68 percent.

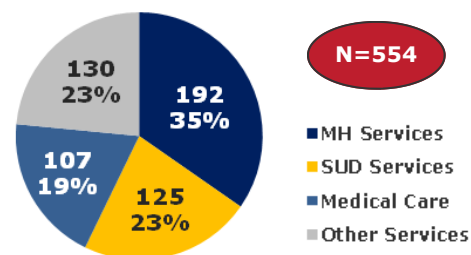
Psychiatric Hospital Use: At 30 percent, this strategy had the second highest average incidence of psychiatric hospital use for all eleven strategies listing this measure as a relevant outcome. Reductions topped out during the third post period for both admissions (-62%) and days (-40%), following increases during the first post period of more than 20 percent.

Intervention Reduced Hospital Charges

In a poster presentation at the 2015 National Behavioral Health Conference, Harborview PES shared that patients reduced ED use by 55 percent and inpatient charges by 63 percent. Pre/post studies showed a significant decline in ED charges for high utilizers receiving brief intensive case management (\$5.5M to \$2.2M).

Other Outcomes: Referrals to mental health (MH) and substance use disorder (SUD) treatment and other services were tracked over the course of MIDD funding for 338 PES clients. Multiple referrals per person were possible. The total number of referrals made, which differ from confirmed linkages, are shown in the graphic below.

Mental Health Referrals Were Most Common



Treatment Linkage: Within one year of starting MIDD services, 223 of the 462 eligible clients (48%) were linked with public sector MH benefits. Slightly fewer individuals were linked to SUD treatment, at 37 percent. A higher percentage of the Asian/Pacific Islanders and multiracial individuals served (over 80%) were linked to MH treatment. A higher percentage of Native Americans clients served (53%) began SUD treatment.



Behavior Modification Classes for Community Center for Alternative Programs (CCAP) Clients

12d

Moral Reconciliation Therapy (MRT) is an evidence-based cognitive-behavioral treatment program proven to be especially effective for clients with substance use disorders (SUD). With MIDD funding, a certified MRT facilitator works with enrolled clients to enhance moral reasoning, to improve their decision-making skills, and to help them engage in more appropriate behaviors. In October 2014, the clinician funded by MIDD transitioned to facilitating MRT classes for a group of individuals assigned to CCAP for domestic violence (DV) offenses.

Primary Policy Goal: Reduce jail recycling for clients with mental illness or SUD

Secondary Policy Goal: Reduce incidence or severity of mental illness or SUD symptoms

		Annual or Adjusted Targets and Performance Measurement							
Measure	Original Target		Year 1 2008-9	Year 2 2009-10	Year 3 2010-11	Year 4 2011-12	Year 5 2012-13	Year 6 2013-14	Year 7 2014-15
Number of Clients	100	Target	25	100	100	100	100	100	40
		Actual	42	79	131	189	162	129	43
		Percent	168%	79%	131%	189%	162%	129%	108%

Target Adjustments and Notes: Year 1 (3 months); Year 7 Target = 40 (change in target population served)

Strategy 12d Key Findings Summary

Jail Use: Total jail bookings for MRT clients were reduced in all five post periods studied. Days associated with these bookings rose in the first two post periods, then fell in the last three. For the 94 people eligible for the fifth post period analysis, aggregate bookings were reduced from 162 to 42 (-74%); jail days declined from 2,943 to 1,087 (-63%).

An analysis was done using a sample of 116 MRT clients who began services before July 2012 and had both level-of-completion information and some change in jail use over time. On average, those who reduced their jail bookings had slightly higher levels of completion than individuals whose jail bookings increased. Reductions in jail days, however, appeared to be more closely related to service completions. For example, only half of those at the lowest completion level reduced jail days compared to 64 percent of clients with higher completion levels. Of the 38 people who had fewer than 30 service hours, 26 (68%) reduced jail days, while 22 of 27 with over 125 service hours (82%) reduced jail days.

Symptoms: Problem Severity Summary (PSS) scores were available at two different time points for 235 MRT participants. Anxiety scores remained stable for 113 people (48%). Of the remaining 122 people who experienced a change, 103 (84%) had improved symptoms as some point during their program participation. For depression, half of all clients remained stable, but 101 of the 117 with change over time (86%) showed improvements.

In a report entitled "Describing the Community Center for Alternative Programs Client Population Behavior Health Needs" written for calendar year 2010, author Geoff Miller used data from the Global Appraisal of Individual Needs Short Screener (GAIN-SS) to show the need for mental health and substance use disorder treatment. In a sample of 530 CCAP clients, 366 (69%) screened indicating probable high severity behavioral health treatment needs. Co-occurring disorders were evident in 334 of these clients (63%).

Please see the client success story for MRT on Page 34 of this report.



Adult Drug Court Expansion of Recovery Support Services

15a

The Adult Drug Court (ADC) within King County's Judicial Administration has offered clients supplemental services with MIDD support. In addition to enhancing educational opportunities for people with learning disabilities, the ADC employs 1.5 housing case management specialists. These case managers help clients with substance use disorders (SUD) find and keep drug-free housing. In 2012, the court secured eight recovery-oriented transitional housing units with on-site case management for transition age youth (18 to 24 years), replacing Young Adult Wraparound. In 2015, MIDD evaluation began tracking all ADC clients in the base court, in addition to those engaged in the expansion services.

Primary Policy Goal: Divert clients with SUD from justice system involvement

Secondary Policy Goal: Reduce incidence or severity of SUD symptoms

		Annual or Adjusted Targets and Performance Measurement							
Measure	Revised Target		Year 1 2008-9	Year 2 2009-10	Year 3 2010-11	Year 4 2011-12	Year 5 2012-13	Year 6 2013-14	Year 7 2014-15
Number of Clients	250 expansion cases	Target	113	300	250	250	250	250	250
		Actual	125	337	313	294	268	261	388
		Percent	111%	112%	125%	118%	107%	104%	155%

Target Adjustments and Notes: Year 1 (3 months); Year 1 Target = 450; Year 2 Target = 300
Adding a target of 300 base court cases (non-expansion) per year has been recommended on Page 52.

Strategy 15a Key Findings Summary

Jail Use: Participants in ADC reduced their jail bookings in each of the five post periods studied. The third and fourth post samples reduced use by 57 percent each, with the fifth period sample topping out at 59 percent. The sum of jail days for individuals in their first program year rose from 29,822 (Pre) to 72,502 (Post 1), an increase of 143 percent. Reductions were evident by the third post (-27%), followed by greater long-term declines in excess of 40 percent.

Analysis of services indicated that higher levels of participation may have a positive impact on jail use changes over time. For example, using the fourth post sample, 72 percent of clients with less than two hours of housing case management reduced their jail bookings versus 78 percent of those with more than two hours.

In a recent analysis, 78 percent of ADC clients reduced drug use to zero or stayed drug free from admission to discharge.

Symptoms: As reported in the MIDD Year Seven Progress Report (August 2015), 937 ADC clients were eligible for outcomes assessment. Case matching found 1,199 treatment starts for 629 people (a 67% match rate). The average number of treatment episodes per person was 1.9, whereby each episode spanned from admission to discharge or loss to follow-up. The most common substance used by ADC clients was marijuana (22%).

Changes in drug use were assessed at two time points, depending on data availability, as shown.

Many people report no drug use in the 30 days before they start treatment.

	Admission to First Milestone		Admission to Discharge	
	N	%	N	%
Decreased use	43	74%	168	46%
Increased use	13	22%	21	6%
Use not changed	2	3%	177	48%
Total with use	58	100%	366	100%
No use/No change	159	-	569	-
Total cases	217	-	935	-

Strategy 16a

New Housing
& Rental
Subsidies



New Housing Units and Rental Subsidies

16a

Prior to full implementation of the MIDD, Strategy 16a appropriated capital funding to expedite construction of new housing units to benefit the MIDD's target population. While the majority of these housing units currently receive ongoing funding for supportive services under Strategy 3a, one capital-funded project (Brierwood) does not, so those clients are tracked here, rather than on Page 22. This strategy also provides 25 rental subsidies per year, from previously allocated funds.

Primary Policy Goals: Reduce jail, emergency room and psychiatric hospital use and link with other Council-directed initiatives

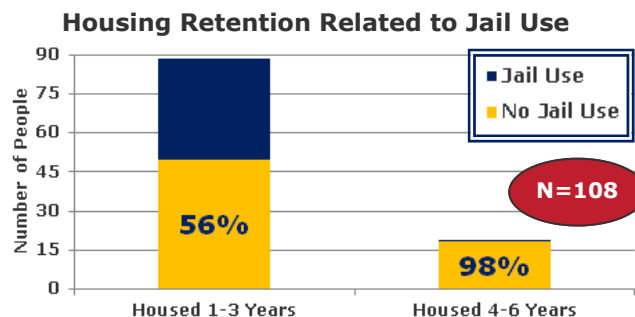
		Annual or Adjusted Targets and Performance Measurement							
Measure	Revised Target		Year 1 2008-9	Year 2 2009-10	Year 3 2010-11	Year 4 2011-12	Year 5 2012-13	Year 6 2013-14	Year 7 2014-15
Number of Tenants	25	Target	0	25	25	25	25	25	25
		Actual	0	25	31	29	28	26	23
		Percent	N/A	100%	124%	116%	112%	104%	92%
Number of Rental Subsidies	25	Target	38	50	40	40	25	25	25
		Actual	27	52	52	41	31	25	19
		Percent	71%	104%	130%	103%	124%	100%	76%

Target Adjustments and Notes: Year 1 (9 months); Years 1 & 2 Target = 50 + Years 3 & 4 Target = 40 (subsidies)

Strategy 16a Key Findings Summary

Initiative Linkage: As stated in 2007's King County Council Ordinance 15949, programs funded by the MIDD were intended to "enable the implementation of a full continuum of treatment, housing and case management services that focus on the prevention and reduction of chronic homelessness and unnecessary involvement in the criminal justice and emergency medical systems and promote recovery for persons with disabling mental illness and chemical dependency." Linked with King County's Ten-Year Plan to End Homelessness, the MIDD budgeted \$18 million in 2008 and another \$6.4 million in 2009 toward housing capital expenditures. These funds supported seven housing projects that created 335 new "beds" for individuals coping with mental illness or substance use disorders. Since the start of the Ten-Year Plan, 6,314 new units of permanent housing with supportive services were created, bringing the countywide total in 2015 to 8,337 units, yet homelessness persists and continues to rise in the region.

Jail use: Reductions in aggregate jail bookings for strategy clients ranged from 40 percent (Post 1) to 77 percent (Post 4). Days in jail were reduced by a maximum of 74 percent, from 2,099 days (Pre) to 555 (Post 4). No jail use was recorded for 98 percent of the 19 clients who remained housed for at least four years as shown below.



Emergency Department (ED) Use:

Harborview ED admissions declined in all five post periods. The greatest decline was 49 percent (Post 4).

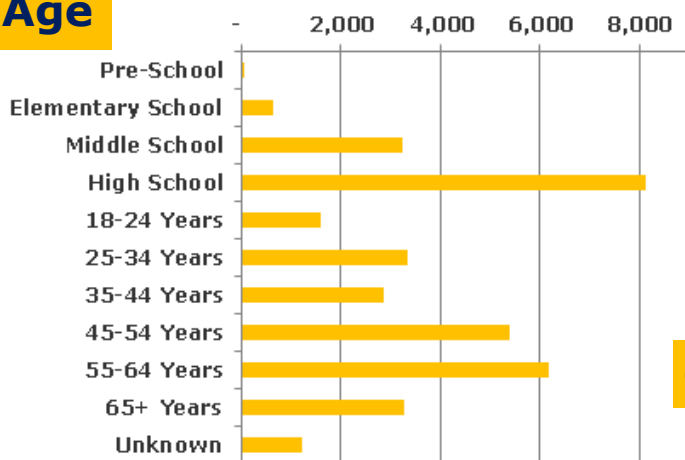
Psychiatric Hospital Use: Both psychiatric hospitalizations (-77%) and days (-86%) were reduced the most in the fifth post period.

MIDD Demographics and Access to Services

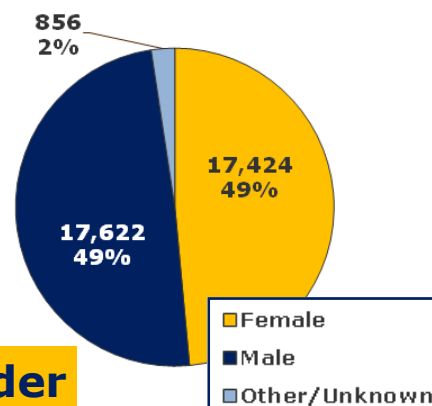
Information on age group, gender, primary race and King County region was available for 35,902 unduplicated people who received at least one MIDD-funded service between October 2014 and September 2015. Those with duplicate demographics across strategies and multiple data sources were counted only once here. The number of unduplicated people with demographics represents a six percent increase over the prior year, largely due to a substantial increase in older adults screened in primary care settings. Even more clients, who could not be unduplicated, were served in large groups through school-based services (N=19,401) and the MIDD's family support organization (N=2,329).

Demographic Distributions for Unduplicated MIDD Year Seven Clients

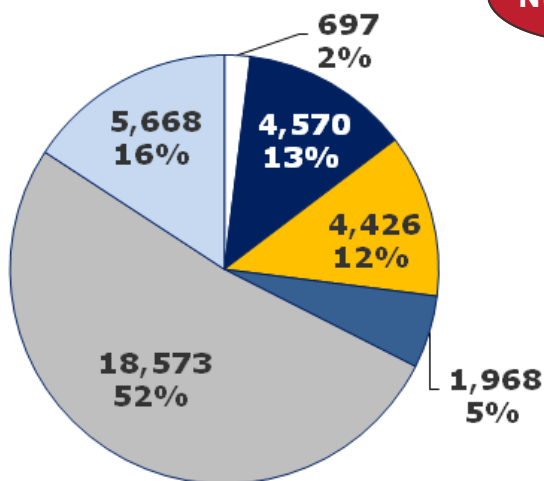
Age



Gender



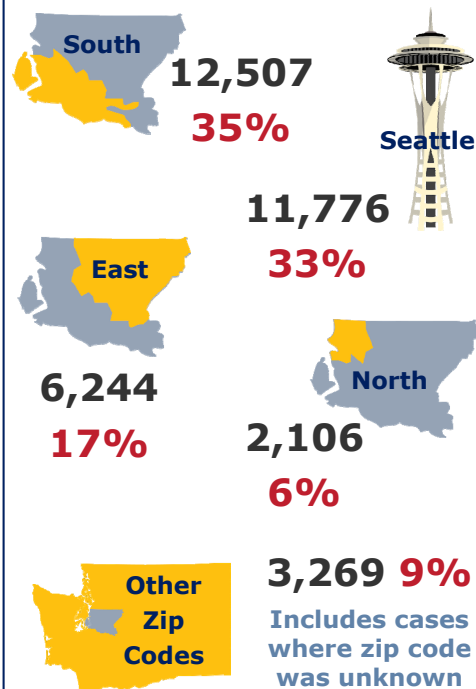
N=35,902



Primary Race

	Portion Known to be Hispanic
Native American	9%
African American/Black	2%
Asian/Pacific Islander	2%
Multiple Races	21%
Caucasian/White	7%
Other/Unknown	56%

King County Region



Demographic Profiles by MIDD Strategy Using Representative Samples

				Gender			Race			Veteran Status			Age		
MIDD Strategies		Earliest MIDD Start	Sample Size*	Female	Male	Other or Unk	White	Persons of Color	Unk	Yes	No	Unk	Child or Youth	Adult	Unk
1a-1	Mental Health Treatment	10/1/2008	8,588	51%	49%	0%	46%	54%	0%	4%	64%	31%	16%	84%	0%
1a-2	Substance Use Disorder Treatment	10/1/2008	11,777	29%	71%	0%	51%	40%	9%	3%	77%	20%	11%	89%	0%
1b	Outreach & Engagement	7/1/2009	4,637	37%	62%	1%	55%	36%	9%	5%	83%	12%	0%	97%	3%
1c	Emergency Room Intervention	1/1/2009	16,192	34%	66%	0%	64%	33%	3%	7%	88%	5%	1%	99%	0%
1d	Crisis Next Day Appts	10/1/2008	2,820	43%	57%	0%	65%	35%	0%	3%	47%	50%	0%	100%	0%
1e	Chemical Dependency Trainings														
1f	Parent Partners Family Assistance	8/5/2013	137	91%	9%	0%	49%	50%	1%	0%	96%	4%	0%	98%	2%
1g	Older Adults Prevention	1/1/2009	11,359	58%	42%	0%	52%	36%	12%	4%	68%	28%	0%	100%	0%
1h	Older Adults Crisis & Svcs Link	10/1/2008	2,206	63%	37%	0%	81%	19%	0%	17%	61%	22%	0%	100%	0%
2a	Workload Reduction														
2b	Employment Services	10/1/2008	2,867	49%	51%	0%	54%	46%	0%	3%	65%	32%	0%	100%	0%
3a	Supportive Housing	1/1/2009	1,290	31%	69%	0%	50%	48%	2%	15%	79%	6%	0%	100%	0%
4a	Parents in Recovery Services														
4b	SUD Prevention for Children														
4c	School-Based Services	7/7/2011	1,979	54%	46%	0%	35%	61%	4%	0%	0%	100%	98%	2%	0%
4d	Suicide Prevention Training	(Years 4-6)	29,868	44%	44%	12%	44%	40%	16%				89%	11%	0%
5a	Juvenile Justice Assessments	7/1/2009	2,048	28%	72%	0%	32%	67%	1%	0%	1%	99%	96%	4%	0%
6a	Wraparound	7/1/2009	1,267	32%	68%	0%	57%	42%	1%	0%	22%	78%	95%	5%	0%
7a	Youth Reception Centers														
7b	Expand Youth Crisis Services	10/1/2011	2,710	53%	47%	0%	50%	39%	11%	0%	9%	91%	98%	2%	0%
8a	Family Treatment Court	1/1/2009	164	81%	19%	0%	53%	46%	1%	3%	96%	1%	1%	99%	0%
9a	Juvenile Drug Court	1/1/2009	247	21%	79%	0%	19%	72%	9%	0%	20%	80%	96%	4%	0%
10a	Crisis Intervention Team Training														
10b	Adult Crisis Diversion	10/1/2011	3,465	42%	58%	0%	60%	31%	9%	7%	59%	34%	0%	100%	0%
11a	Increase Jail Liaison Capacity	1/1/2009	700	1%	99%	0%	45%	47%	8%	5%	61%	34%	0%	100%	0%
11b	Mental Health Courts	10/1/2010	1,354	28%	72%	0%	54%	44%	2%	5%	68%	27%	0%	99%	1%
12a	Jail Re-Entry& Education Classes	1/1/2009	3,536	26%	71%	3%	42%	42%	16%	2%	38%	60%	0%	97%	3%
12b	Hospital Re-Entry Respite Beds	10/1/2011	913	22%	78%	0%	60%	37%	3%	9%	87%	4%	0%	100%	0%
12c	Psychiatric Emergency Svcs Link	10/1/2008	462	23%	77%	0%	54%	45%	1%	6%	65%	29%	0%	100%	0%
12d	Behavior Modification Classes	7/1/2009	584	17%	83%	0%	52%	47%	1%	4%	62%	34%	0%	100%	0%
13a	Domestic Violence Services	2/1/2009	2,030	95%	1%	4%	50%	49%	1%	1%	96%	3%	0%	98%	2%
13b	Domestic Violence Prevention	10/1/2008	984	68%	32%	0%	50%	48%	2%	1%	66%	33%	57%	39%	4%
14a	Sexual Assault Services	10/1/2008	1,191	84%	14%	2%	48%	51%	1%	3%	83%	14%	34%	65%	1%
15a	Adult Drug Court	10/1/2008	1,054	28%	72%	0%	42%	57%	1%	5%	94%	1%	0%	100%	0%
16a	New Housing & Rental Subsidies	10/1/2008	161	44%	56%	0%	61%	38%	1%	3%	68%	29%	0%	100%	0%

* Samples of MIDD participants with service starts prior to 9/30/2014, unduplicated within strategy.

Grayed strategies were not implemented or do not currently track individual-level demographic information.

Highlighted Demographic Differences by MIDD Strategy

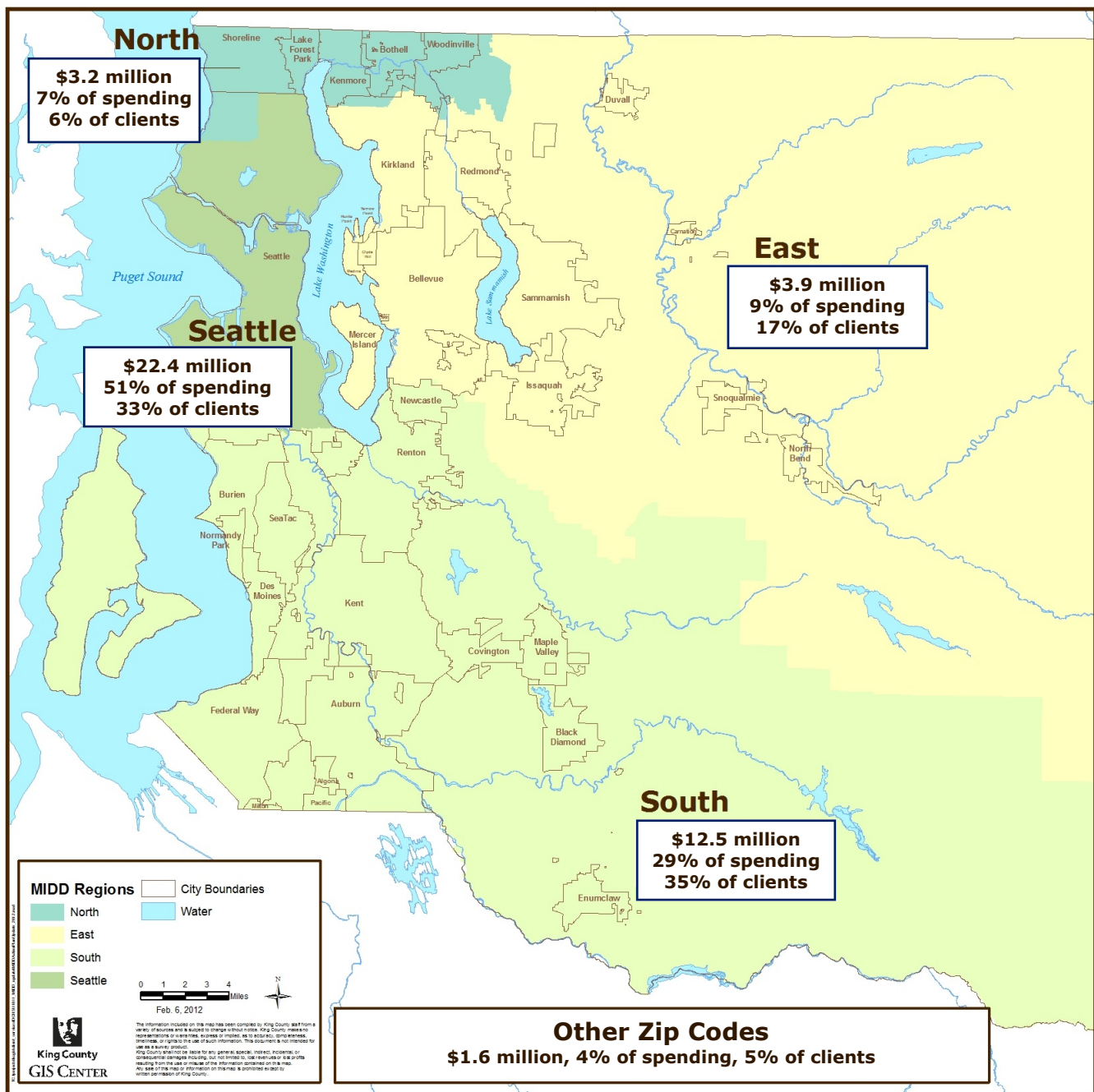
	Greater than 70% of clients were male	Strategy 1a-2 Substance Use Disorder Treatment  Strategy 5a Juvenile Justice Assessments 	Strategy 9a Juvenile Drug Court  Strategy 11a Increase Jail Liaison Capacity 	Strategy 11b Mental Health Courts  Strategy 12a Jail Re-Entry & Education Classes 	Strategy 12b Hospital Re-Entry Respite Beds  Strategy 12d Behavior Modification Classes 	Strategy 15a Adult Drug Court 
	Greater than 70% of clients were female	Strategy 1f Parent Partners Family Assistance 	Strategy 8a Family Treatment Court 	Strategy 13a Domestic Violence Services 	Strategy 13b Domestic Violence Prevention 	Strategy 14a Sexual Assault Services 

Top Three Strategies Serving Persons of Color

Strategy 4c School-Based Services 	Strategy 5a Juvenile Justice Assessments 	Strategy 9a Juvenile Drug Court 
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Homeless status was tracked for 29,273 cases (one person per strategy) in the current period. Of those cases, 5,886 (20%) were experiencing homelessness. More than 80 percent of clients in Strategy 1b—Outreach & Engagement and Strategy 12b—Hospital Re-Entry Respite beds were not housed at the start of MIDD services.

Approximate 2015 MIDD Spending Exclusive of Supplantation Expense and Percent of Year Seven Clients by King County Region



For most strategies, known and valid zip codes for MIDD program participants between October 2014 and September 2015 were used to calculate approximate regional distributions for each MIDD strategy. Where zip codes were not available (four percent of all MIDD Year Seven clients), provider catchment areas or other location data contributed to determining regional distributions. Actual funds expended during calendar year 2015 (January 1 through December 31, 2015) were then apportioned to each King County region by multiplying the total strategy expense, as reported in Parts I and II of the MIDD Financial Report (see Pages 49 and 50), by the regional distributions for each strategy. The rounded sums of all strategy expenditures attributed to each region are shown above. Supplantation expenses, in excess of \$8.5 million during 2015, are not factored into this graphic. Four strategies with spending over \$2 million each were heavily weighted toward the Seattle region: Strategy 2a—Workload Reduction, Strategy 3a—Supportive Housing, Strategy 10b—Adult Crisis Diversion, and Strategy 11b—Mental Health Courts.

MIDD Financial Reports

Financial information provided over the next three pages is for calendar year 2015 (January 1 through December 31, 2015). The MIDD sales tax fund spent just over \$49.3 million in strategy, therapeutic courts, and other funding and over \$8.5 million in MIDD supplantation. The unreserved fund balance on December 31, 2015 was nearly \$9.2 million. Parts I and II show budgeted and actual spending by category. Also included in the financial report are detailed supplantation spending, summary revenues/expenditures, and fund balance information. Please note that strategies 13a and 14a share funds, as needed.

	Strategy	2015 Annual Budget	2015 Actual Year-to-Date (December 31, 2015)	Actual vs Budget (Rounded)
1a-1	Increase Access to Community Mental Health Treatment & Club House	\$ 8,042,759	\$ 7,319,006	91%
1a-2	Increase Access to Community Substance Abuse Treatment	\$ 2,485,124	\$ 3,333,243	134%
1b	Outreach and Engagement to Individuals Leaving Hospitals, Jails or Crisis Facilities	\$ 502,100	\$ 473,292	94%
1c	Emergency Room Substance Abuse Early Intervention Program	\$ 660,790	\$ 594,464	90%
1d	Mental Health Crisis Next Day Appointments and Stabilization Services	\$ 228,700	\$ 253,693	111%
1e	Chemical Dependency Professional Education and Training	\$ 688,542	\$ 714,254	104%
1f	Parent Partner and Youth Peer Support Assistance Program	\$ 380,465	\$ 466,811	123%
1g	Prevention and Early Intervention Mental Health and Substance Abuse Services for Adults Age 50+	\$ 450,000	\$ 439,906	98%
1h	Expand Availability of Crisis Intervention and Linkage to On-Going Services for Older Adults	\$ 319,653	\$ 319,653	100%
2a	Workload Reduction for Mental Health	\$ 4,000,000	\$ 4,000,000	100%
2b	Employment Services for Individuals with Mental Illness and Chemical Dependency	\$ 1,000,215	\$ 1,161,455	116%
3a	Supportive Services for Housing Projects	\$ 2,000,000	\$ 2,000,000	100%
4a	Services for Parents in Substance Abuse Outpatient Treatment	\$ -	\$ -	
4b	Prevention Services to Children of Substance Abusers	\$ -	\$ -	
4c	Collaborative School-Based Mental Health and Substance Abuse Services	\$ 1,277,853	\$ 1,180,704	92%
4d	School-Based Suicide Prevention	\$ 202,954	\$ 200,000	99%
5a	Expand Assessments for Youth in the Juvenile Justice System	\$ 179,006	\$ 142,068	79%
6a	Wraparound Services for Emotionally Disturbed Youth	\$ 4,565,770	\$ 4,363,035	96%
7a	Reception Centers for Youth in Crisis	\$ -	\$ -	
7b	Expansion of Children's Crisis Outreach Response Service System	\$ 507,366	\$ 506,096	100%
8a	Expand Family Treatment Court Services and Support to Parents	\$ 82,476	\$ 76,108	92%
9a	Expand Juvenile Drug Court Treatment (See Part II)	\$ -	\$ -	
10a	Crisis Intervention Team Training for First Responders	\$ 775,278	\$ 538,292	69%
10b	Adult Crisis Diversion Center, Respite Beds and Mobile Behavioral Health Crisis Team	\$ 6,190,100	\$ 5,680,206	92%
11a	Increase Jail Liaison Capacity	\$ 81,256	\$ 57,919	71%
11b	Increase Services for New or Existing Mental Health Court Programs	\$ 703,404	\$ 624,937	89%
12a	Jail Re-Entry Program Capacity Increase	\$ 323,988	\$ 322,464	100%
12b	Hospital Re-Entry Respite Beds	\$ 516,011	\$ 507,272	98%
12c	Increase Harborview's Psychiatric Emergency Services Capacity to Link Individuals to Community Services upon ER Discharge	\$ 202,954	\$ 202,954	100%
12d	Behavior Modification Classes for CCAP Clients	\$ 76,107	\$ 83,264	109%
13a	Domestic Violence and Mental Health Services	\$ 254,720	\$ 318,064	125%
13b	Domestic Violence Prevention	\$ 227,308	\$ 227,308	100%
14a	Sexual Assault, Mental Health and Chemical Dependency Services	\$ 404,880	\$ 325,285	80%
15a	Drug Court: Expansion of Recovery Support Services	\$ 103,778	\$ 103,685	100%
16a	New Housing Units and Rental Subsidies	\$ -	\$ -	
	Behavioral Health Data Integration - MIDD Data System	\$ 982,633	\$ 982,633	100%
	MIDD Evaluation and Treatment Capital	\$ 1,214,770	\$ 1,214,770	100%
	Sexual Assault Supplantation	\$ 362,000	\$ 362,000	100%
	MIDD Administration	\$ 3,121,252	\$ 3,208,454	103%
	Total MIDD Operating Dollars	\$ 43,114,212	\$ 42,303,296	98%

Mental Illness and Drug Dependency Fund - Part II

	Other MIDD Funds (Separate Appropriation Units)	2015 Annual Budget	2015 Actual Year-to-Date (December 31, 2015)	Actual vs Budget (Rounded)
	Department of Judicial Administration	\$ 1,636,165	\$ 1,492,027	91%
	Adult Drug Court Base	\$ 1,636,165	\$ 1,342,564	82%
15a	Drug Court: Expansion of Recovery Support Services	\$ -	\$ 149,463	
	Prosecuting Attorney's Office	\$ 1,247,185	\$ 1,281,670	103%
	Adult Drug Court Base	\$ 583,770	\$ 646,303	111%
	Juvenile Drug Court Base	\$ 121,774	\$ 81,185	67%
	Mental Health Court Base	\$ 541,641	\$ 544,712	101%
11b	Mental Health Court Expansion	\$ -	\$ 9,470	
	Superior Court	\$ 1,702,141	\$ 1,718,256	101%
	Adult Drug Court Base	\$ 172,480	\$ 171,899	100%
	Juvenile Drug Court Base	\$ -	\$ -	
	Family Treatment Court Base	\$ -	\$ -	
5a	Expand Assessments for Youth in the Juvenile Justice System	\$ 235,182	\$ 221,546	94%
8a	Expand Family Treatment Court Services and Support to Parents	\$ 672,591	\$ 712,706	106%
9a	Expand Juvenile Drug Court Treatment	\$ 621,888	\$ 612,105	98%
	Sheriff Pre-Booking Diversion	\$ 175,527	\$ 171,161	98%
10a	Crisis Intervention Team Training for First Responders	\$ 175,527	\$ 171,161	98%
	Department of Public Defense	\$ 1,482,761	\$ 1,423,325	96%
	Adult Drug Court Base	\$ 638,434	\$ 719,720	113%
	Juvenile Drug Court Base	\$ 83,443	\$ 82,274	99%
	Mental Health Court Base	\$ 440,119	\$ 301,247	68%
	Family Treatment Court Base	\$ 320,765	\$ 320,000	100%
8a	Expand Family Treatment Court Services and Support to Parents	\$ -	\$ -	
9a	Expand Juvenile Drug Court Treatment	\$ -	\$ -	
11b	Increase Services for New or Existing Mental Health Court Programs	\$ -	\$ 84	
	District Court	\$ 1,039,385	\$ 925,412	89%
	Mental Health Court Base	\$ 1,039,385	\$ 918,693	88%
11b	Mental Health Court Expansion	\$ -	\$ 6,719	
	Total Other MIDD Funds	\$ 7,283,163	\$ 7,011,850	96%
	Total All MIDD Funds	\$ 50,397,375	\$ 49,315,146	98%

Mental Illness and Drug Dependency Fund - Supplantation Details

Strategy	2015 Annual Budget	2015 Actual Year-to-Date (December 31, 2015)	Actual vs Budget (Rounded)
MIDD Supplantation			
Department of Adult and Juvenile Detention	\$ 367,363	\$ 367,360	100%
Community Center for Alternate Programs (CCAP)	\$ 28,644	\$ 28,644	100%
Juvenile MH Treatment	\$ 338,719	\$ 338,716	100%
Jail Health Services	\$ 3,738,671	\$ 3,648,425	98%
Psychiatric Services	\$ 3,738,671	\$ 3,648,425	98%
MH & SUD MIDD Supplantation	\$ 4,984,807	\$ 4,528,609	91%
SUD Administration	\$ 399,752	\$ 399,752	100%
Criminal Justice Initiative	\$ 1,031,111	\$ 838,452	81%
SUD Contracts	\$ 271,757	\$ 138,351	51%
Housing Voucher Program	\$ 602,615	\$ 602,615	100%
SUD Emergency Service Patrol	\$ 505,325	\$ 519,133	103%
CCAP	\$ 472,981	\$ 475,458	101%
MH Co-Occurring Disorders Tier	\$ 800,000	\$ 629,735	79%
MH Recovery	\$ 187,660	\$ 187,760	100%
MH Juvenile Justice Liaison	\$ 90,000	\$ 91,665	102%
MH Crisis Respite Beds	\$ 263,606	\$ 297,196	113%
MH Functional Family Therapy	\$ 272,000	\$ 251,582	92%
MH Mental Health Court Liaison	\$ 88,000	\$ 96,910	110%
Total MH/SUD MIDD Supplantation Funds	\$ 9,090,841	\$ 8,544,394	94%

Mental Illness and Drug Dependency Fund Total Revenues and Expenditures

	2015 Annual Budget	2015 Actual Year-to-Date (December 31, 2015)
MIDD Tax	\$ 54,238,144	\$ 55,812,826
Streamlined Mitigation	\$ 650,000	\$ 594,183
Investment Interest - Gross	\$ 55,000	\$ 51,405
Cash Management Svcs Fee		\$ (771)
Invest Service Fee - Pool		\$ 3
Other Miscellaneous Revenue		\$ 217
Total Revenues	\$ 54,943,144	\$ 56,457,862
Total MIDD Funds	\$ 50,397,375	\$ 49,315,146
Total MIDD Supplantation	\$ 9,090,841	\$ 8,544,394
Total Expenditures	\$ 59,488,216	\$ 57,859,540
Revenues Over Expenditures	\$ (4,545,072)	\$ (1,401,678)

Mental Illness and Drug Dependency Fund Balance Analysis

MIDD Fund Balance Analysis		
Unreserved Fund Balance as of December 31, 2014	\$	10,966,498
Revenue Stabilization Reserve as of December 31, 2014	\$	5,275,885
Revenue		56,457,862
Expenditures		57,859,540
		(1,401,678)
Unreserved Fund Balance December 31, 2015	\$	9,194,919
Revenue Stabilization Reserve December 31, 2015	\$	5,645,786

Recommended Strategy Revisions

Implementation, evaluation and oversight of the MIDD sales tax fund requires occasional plan modifications. The MIDD Evaluation Plan and associated evaluation matrices were developed in May 2008 by Mental Health, Chemical Abuse and Dependency Services Division staff based on the strategy-level implementation plans available at that time. In August 2012, updated matrices were published in the MIDD Year Four Progress Report and matrices modified since that time were published in August of 2013, 2014, and 2015. For the current reporting period, proposed adjustments to performance targets and/or methods of measurement are provided below.

Strategy Number	Strategy Name	MIDD Year 8 Revised Performance Target	Explanation for Proposed Revision
1a-2	Substance Use Disorder Treatment	To Be Determined	Current targets are not reflective of all services being provided by this strategy.
2b	Employment Services	Set target to serve 75 clients in substance use disorder (SUD) treatment per year who express a desire to work.	Pilot program was renewed for one year. Target is based on the number of clients specified in contract.
11b	Mental Health Courts (MHC)	Reset the target for Regional Mental Health Court (RMHC) expansion cases to serving 110 additional clients over a two-year period, or 55 annually, with two full-time equivalent (FTE) expansion probation staff. Continue to track outcomes for 165 non-expansion cases over a two-year period, or 83 annually.	The new target is based on a budget restoration from one FTE expansion probation staff (whose caseload size limits the number of clients to be served) to two FTE expansion staff. Three non-expansion staff continue to serve the remaining clients.
15a	Adult Drug Court (ADC)	Set target of 300 base ADC clients served per year, in addition to the 250 clients per year who receive expanded recovery support services. Adjust expansion clients down to 230 per year if the contract to provide CHOICES classes is not renewed.	The proposed target is based on reporting of 315 base ADC clients during MIDD Year Seven. An adjustment to the expansion target may be necessary if a contracted staff position cannot be filled.

Appendix I: MIDD Strategy Alignment with Policy Goals

Strategy Number	Strategy Name	Strategy Description	MIDD Policy Goals				
			#1	#2	#3	#4	#5
1a-1	Mental Health Treatment	Increase Access to Community Mental Health (MH) Treatment	+		★		
1a-2	Substance Use Disorder Treatment	Increase Access to Community Substance Use Disorder (SUD) Treatment	+		★		
1b	Outreach & Engagement	Outreach and Engagement to Individuals Leaving Hospitals, Jails or Crisis Facilities	★				+
1c	Emergency Room Intervention	Emergency Room Substance Abuse Early Intervention Program	★				
1d	Crisis Next Day Appts	Mental Health Crisis Next Day Appointments and Stabilization Services	★				
1e	Chemical Dependency Trainings	Chemical Dependency Professional Education and Training					★
1f	Parent Partners Family Assistance	Parent Partner and Youth Peer Support Assistance Program					★
1g	Older Adults Prevention	Prevention and Early Intervention Mental Health and Substance Abuse Services for Adults Age 50+	+		★		
1h	Older Adults Crisis & Service Linkage	Expand Availability of Crisis Intervention and Linkage to Ongoing Services for Older Adults	★				
2a	Workload Reduction	Workload Reduction for Mental Health					★
2b	Employment Services	Employment Services for Individuals with Mental Illness and Substance Use Disorder					★
3a	Supportive Housing	Supportive Services for Housing Projects	★				+
4a	Parents in Recovery Services	Services for Parents in Substance Abuse Outpatient Treatment			★		
4b	SUD Prevention for Children	Prevention Services to Children of Substance Abusing Parents			★	+	
4c	School-Based Services	Collaborative School-Based Mental Health and Substance Abuse Services			★	+	
4d	Suicide Prevention Training	School-Based Suicide Prevention					★
5a	Juvenile Justice Assessments	Expand Assessments for Youth in the Juvenile Justice System		★		★	
6a	Wraparound	Wraparound Services for Emotionally Disturbed Youth	★		+	★	
7a	Youth Reception Centers	Reception Centers for Youth in Crisis	★			★	
7b	Expand Youth Crisis Services	Expansion of Children's Crisis Outreach Response Service System (CCORS)	★			+	
8a	Family Treatment Court	Family Treatment Court Expansion		★	★		
9a	Juvenile Drug Court	Juvenile Drug Court Expansion			★	★	
10a	Crisis Intervention Team Training	Crisis Intervention Training for First Responders					★
10b	Adult Crisis Diversion	Adult Crisis Diversion Center, Respite Beds, and Mobile Crisis Team	★			★	
11a	Increase Jail Liaison Capacity	Increase Jail Liaison Capacity		★			
11b	Mental Health Courts	Increase Services for New or Existing Mental Health Court Programs			+	★	
12a	Jail Re-Entry & Education Classes	Jail Re-Entry Program Capacity Increase & Education Classes at Community Center for Alternative Programs (CCAP)		★			
12b	Hospital Re-Entry Respite Beds	Hospital Re-Entry Respite Beds (Recuperative Care)	★				
12c	Psychiatric Emergency Services Linkage	Increase Harborview's Psychiatric Emergency Services Capacity	★				
12d	Behavior Modification Classes	Behavior Modification Classes for CCAP Clients		★	+		
13a	Domestic Violence Services	Domestic Violence and Mental Health Services			★		+
13b	Domestic Violence Prevention	Domestic Violence Prevention			★		+
14a	Sexual Assault Services	Sexual Assault and Mental Health Services			★		+
15a	Adult Drug Court	Adult Drug Court Expansion of Recovery Support Services			+	★	
16a	New Housing & Rental Subsidies	New Housing Units and Rental Subsidies	★				★
17a	Crisis Intervention/MH Partnership	Crisis Intervention Team/Mental Health Partnership Pilot	+				★
17b	Safe Housing - Child Prostitution	Safe Housing and Treatment for Children in Prostitution Pilot				+	★

Key: ★ = Primary Goal + = Secondary Goal

Note: Grayed items were not implemented or were piloted only.

Goals:

#1	Reduce jail, emergency room and/or hospital use by mentally ill or drug dependent clients
#2	Reduce jail recycling for mentally ill or drug dependent clients
#3	Reduce incidence and severity of mental illness and/or drug dependency symptoms
#4	Divert mentally ill or drug dependent clients from initial or further justice system involvement
#5	Linkage with other Council-directed initiatives such as the Plan to End Homelessness, the Veterans and Human Services Levy and the King County Mental Health Recovery Plan

Appendix II: Performance Measures by Strategy Category

Community-Based Mental Health and Substance Use Disorder Intervention Strategies



More than 85% of target



65% - 85% of target



Less than 65% of target

Year 7 Targets	Continued Services from Prior Year(s)	New in Year 7	Year 7 Totals ¹	Percent of Year 7 Target	Target Success Rating
1a-1 - Increase Access to Community Mental Health (MH) Treatment					
2,400 clients/yr	1,866	864	2,730	114%	↑
1a-2 - Increase Access to Community Substance Use Disorder (SUD) Treatment					
50,000 adult OP units	N/A	20,362 adult OP units	41%	↓	
4,000 youth OP units		2,833 youth OP units	71%	→	
70,000 OTP units		21,231 OTP units	30% ²	↓	
1b - Outreach and Engagement to Individuals Leaving Hospitals, Jails or Crisis Facilities					
675 clients/yr	385	689	1,074	159% ³	↑
1c - Emergency Room Substance Abuse Early Intervention Program					
6,400 screens/yr (8 FTE) Adjust to 4,560 screens/yr (5.7 FTE)	N/A	2,177 screens	48% (Adjusted)	↓	
4,340 brief interventions (BI)/yr (8 FTE) Adjust to 3,092 BI/yr (5.7 FTE)		2,585 brief interventions	84% (Adjusted)	→	
1d - Mental Health Crisis Next Day Appointments and Stabilization Services					
750 clients/yr with enhanced services Adjust to 634 with funding restored 1/2015	20	319	339	53% (Adjusted)	↓
1e - Chemical Dependency Professional Education and Training ⁴					
125 reimbursed trainees/yr	188	157	345	276%	↑
250 workforce development trainees/yr	N/A	482	482	193%	
1f - Parent Partner and Youth Peer Support Assistance Program					
400 clients/yr Adjust to 300 clients/yr (fully staffed 1/2015)	38	144	182	61%	↓
1g - Prevention and Early Intervention Mental Health and Substance Abuse Services for Adults Age 50+					
2,500 clients/yr (7.4 FTE) Adjust to 2,196 clients/yr (6.5 FTE)	3,762	5,171	8,933	407% (Adjusted)	↑
1h - Expand Availability of Crisis Intervention and Linkage to Ongoing Services for Older Adults					
340 clients/yr (4.6 FTE) Adjust to 258 clients/yr (3.5 FTE)	50	244	294	114% (Adjusted)	↑
2a - Workload Reduction for Mental Health					
16 agencies participating	16	0	16	100%	↑
2b - Employment Services for Individuals with Mental Illness and SUD					
920 clients/yr Adjust to 700 clients/yr (MH clients only)	477	394	871	124% (Adjusted)	↑
3a - Supportive Services for Housing Projects					
690 clients for MIDD Year Seven	599	173	772	112%	↑
13a - Domestic Violence and Mental Health Services					
560-640 clients/yr	240	355	595	106%	↑
14a - Sexual Assault and Mental Health Services					
170 clients/yr	182	176	358	211% ³	↑

¹ Unduplicated counts per strategy of those receiving at least one service during reporting period, unless otherwise indicated.

² During the current period, the MIDD funded over \$1.75 million in detoxification services.

³ Blended funds allow more clients to be served than the portion attributable to MIDD only, on which performance measurement is based.

⁴ A total of 107 unduplicated CDPTs received clinical supervision funded by Strategy 1e.

Strategies with Programs to Help Youth



More than 85% of target



65% - 85% of target



Less than 65% of target

Year 7 Targets	Continued Services from Prior Year(s)	New in Year 7	Year 7 Totals ¹	Percent of Year 7 Target	Target Success Rating
4a - Services for Parents in Substance Abuse Outpatient Treatment					
400 parents/yr	N/A	N/A	Not implemented	N/A	N/A
4b - Prevention Services to Children of Substance Abusing Parents					
400 children/yr	N/A	N/A	Not implemented	N/A	N/A
4c - Collaborative School-Based Mental Health and Substance Abuse Services					
2,268 youth/yr (19 programs) Adjust to 1,550 youth/yr (13 programs)	265	at least 766 ²	1,031	67% (Adjusted)	→
4d - School-Based Suicide Prevention					
1,500 adults/yr 3,250 youth/yr	N/A	1,072 adults 8,530 youth		71% 262% ³	→ ↑
5a - Expand Assessments for Youth in the Juvenile Justice System					
Coordinate 1,200 (833) assessments/yr Provide 200 psychological services/yr Conduct 140 MH assessments Conduct 165 full SUD assessments Adjusted coordinations due to staff vacancies	N/A	841 coordinations for 379 unique youth 311 psychological services 139 MH assessments 190 full SUD assessments		101% 156% 99% 115%	↑
6a - Wraparound Services for Emotionally Disturbed Youth					
450 enrolled youth/yr	255	303	558	124%	↑
7a - Reception Centers for Youth in Crisis					
TBD	N/A	N/A	Not implemented	N/A	N/A
7b - Expansion of Children's Crisis Outreach Response System (CCORS)					
300 youth/yr	172	871	1,043	348% ³	↑
8a - Family Treatment Court Expansion					
120 children per year ⁴ No more than 60 children at one time	N/A	103 children (in MIDD Year 7) Program monitors daily capacity		86%	↑
9a - Juvenile Drug Court Expansion					
36 new youth/yr	56	83 new opt-ins 6 new pre opt-ins	145	247% (Total new)	↑
13b - Domestic Violence Prevention					
85 families/yr	97	58	155 unique families	182%	↑

¹ Unduplicated counts per strategy of those receiving at least one service during reporting period, unless otherwise indicated.

² Program also serves numerous youth in large groups and assemblies.

³ Blended funds allow more clients to be served than the portion attributable to MIDD only on which the performance measurement targets are based.

⁴ Revised target accepted by Council in motion of acceptance on 7/20/2015.

Jail and Hospital Diversion Strategies



More than 85% of target



65% - 85% of target



Less than 65% of target

Year 7 Targets	Continued Services from Prior Year(s)	New in Year 7	Year 7 Totals ¹	Percent of Year 7 Target	Target Success Rating
10a - Crisis Intervention Team Training for First Responders					
180 trainees/yr (40-hour) 300 trainees/yr (One-day) 150 trainees/yr (Other) ²	N/A	199 (40-hour) 553 (One-day) 312 (Other CIT programs) ³		111% 184% 208%	↑
10b - Adult Crisis Diversion Center, Respite Beds and Mobile Behavioral Health Crisis Team					
3,000 adults/yr	655	2,697	3,352 ³	112%	↑
11a - Increase Jail Liaison Capacity					
200 (100) clients/yr Adjust as noted due to staff vacancies	3	32	35	35% (Adjusted)	↓
11b - Increase Services for New or Existing Mental Health Court Programs					
28 new opt-in expansion clients/yr and ⁴ 83 non-expansion clients/yr for Regional Mental Health Court (RMHC)	32 expansion 77 non-exp.	28 expansion 101 non-exp.	60 expansion 178 non-exp.	100% 122% ⁵ (New cases)	↑
300 clients/yr for Seattle Mental Health Court	21	266	287 screened candidates	96%	
12a-1 - Jail Re-Entry Program Capacity Increase					
300 clients/yr (3 FTE)	33	181	214	71%	→
12a-2 - Education Classes at Community Center for Alternative Programs (CCAP)					
600 clients/yr	36	496	532 ³	89%	↑
12b - Hospital Re-Entry Respite Beds (Recuperative Care)					
350-500 clients/yr	65	301	366	105%	↑
12c - Increase Harborview's Psychiatric Emergency Services (PES) Capacity					
75-100 clients/yr	39	42	81	108%	↑
12d - Behavior Modification Classes for CCAP Clients					
40 clients/yr ⁴	2	41	43	108%	↑
15a - Adult Drug Court Expansion of Recovery Support Services					
250 expansion clients/yr	204	184	388 ⁶	155%	↑
16a - New Housing Units and Rental Subsidies					
25 rental subsidies/yr Tenants in 25 capially-funded beds without MIDD-funded support services through Strategy 3a	14 19	5 4	19 (rental subsidies) 23 tenants (Brierwood)	76% 92%	→ ↑
17a - Crisis Intervention Team/Mental Health Partnership Pilot			COMPLETED		
17b - Safe Housing and Treatment for Children in Prostitution Pilot			COMPLETED		

¹ Unduplicated counts per strategy of those receiving at least one service during reporting period, unless otherwise indicated.

² Other trainings included Youth and Force Options.

³ Not unduplicated - individuals are counted once for participation in each different program component.

⁴ Revised target accepted by Council in motion of acceptance on 7/20/2015.

⁵ Error in Progress Report calculation has been corrected here.

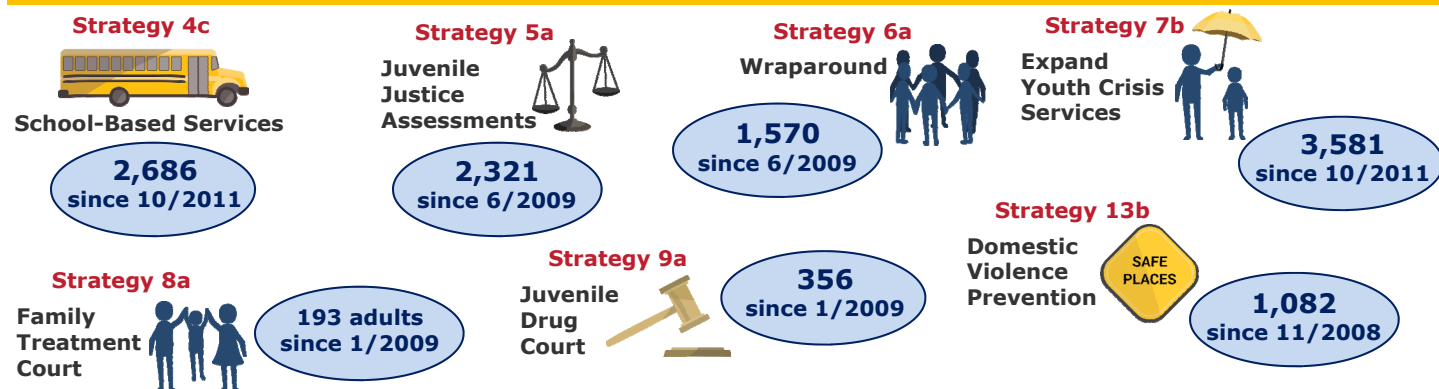
⁶ Began tracking base court clients on 1/1/2015. There were 315 during this reporting period.

Appendix III: Unique Individuals Served from Strategy Start

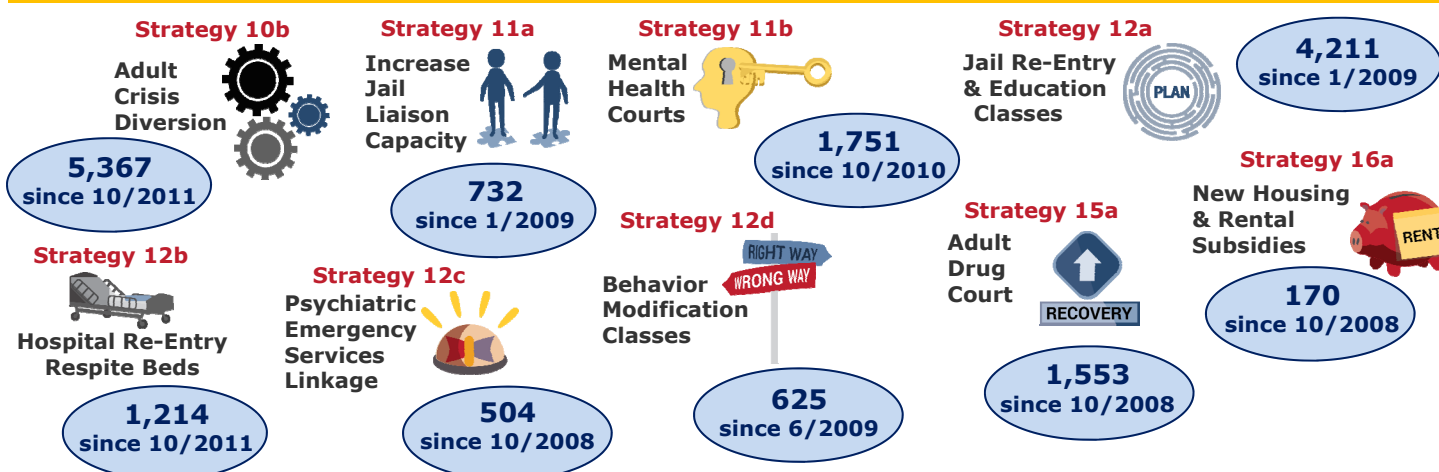
Community-Based Mental Health and Substance Use Disorder Intervention Strategies



Strategies with Programs to Help Youth



Jail and Hospital Diversion Strategies



Note: Unique individuals are not tracked for the following strategies: 2a—Workload Reduction, 4d—Suicide Prevention Training, and 10a—Crisis Intervention Team Training. Two strategies, 1f—Parent Partners Family Assistance and 4c—School-Based Services serve large groups in addition to individuals reported above. Several strategies blend funds to serve more clients.

Appendix IV: MIDD Outcomes Samples and Average Incidence of System Use Over Time for Relevant Strategies

		Eligible for Outcomes on Time Alone					Jail	Harborview Emergency Department	Psychiatric Hospitals
		Post 1	Post 2	Post 3	Post 4	Post 5			
1a-1a	Mental Health Treatment	8,587	7,901	6,806	4,547	3,623	16%	22%	13%
1a-1b	MH Clubhouse Participation Only	313	261	142	0	0	10%	18%	15%
1a-2a	Outpatient SUD Treatment	9,725	8,764	7,582	6,223	4,692	48%	19%	
1a-2a	Detoxification Only	290	0	0	0	0	27%		
1a-2b	Opiate SUD Treatment	2,084	1,930	1,653	1,356	1,201	35%	32%	
1b	Outreach & Engagement	4,630	4,040	3,441	2,686	1,798	40%	43%	5%
1c	Emergency Room Intervention	16,181	14,236	11,225	7,346	4,304	28%	50%	
	Harborview	11,493	10,189	8,030	5,441	3,548	30%	61%	
	South County	4,688	4,047	3,195	1,905	756	22%	19%	
1d	Crisis Next Day Appointments	2,830	2,584	2,325	2,121	1,750	24%	51%	14%
1g	Older Adults Prevention*	4,105	3,545	2,964	2,300	1,443		27%	
1h	Older Adults Crisis & Svc Linkage	2,205	1,838	1,447	1,145	754		9%	4%
2b	Employment Services	3,059	2,512	2,044	1,610	1,224			
3a	Supportive Housing	1,302	1,081	910	694	380	49%	62%	20%
4c	School-Based Services	2,037	1,164	97	0	0	1%		
5a	Juvenile Justice Assessments	2,049	1,629	825	599	299	69%		
6a	Wraparound	1,271	996	718	422	237	25%		
7b	Expand Youth Crisis Services	2,710	1,814	951	0	0	12%	8%	12%
8a	Family Treatment Court	165	142	120	83	53	55%		
9a	Juvenile Drug Court	254	205	124	93	62	83%		
10b	Adult Crisis Diversion	3,464	1,819	290	0	0	33%	54%	28%
11a	Increase Jail Liaison Capacity	700	687	614	413	267	79%		
11b-1	Seattle MH Court Expansion	823	561	267	0	0	94%		
11b-2	Regional Mental Health Court	563	396	242	148	0	75%		
12a-1	Jail Re-Entry Capacity	1,100	954	788	590	423	90%		
12a-2a	Education Classes at CCAP	970	829	661	447	215	79%		
12a-2b	CCAP Domestic Violence Education	1,465	1,106	809	469	269	75%		
12b	Hospital Re-Entry Respite Beds	913	641	297	0	0	41%	77%	9%
12c	PES Linkage	462	415	346	300	226	56%	95%	30%
12d	Behavior Modification Classes	584	494	363	204	94	83%		
15a	Adult Drug Court	1,223	976	816	630	425	84%		
16a	New Housing & Rental Subsidies	161	136	122	108	84	38%	55%	73%

* Limited to those with services beyond screening

Top Three Strategies with Jail Use

Strategy 11b-1 **94%**
Mental Health Courts

Seattle MH Court Expansion

Strategy 12a-1 **90%**
Jail Re-Entry Capacity


Strategy 15a **84%**
Adult Drug Court


Top Three Strategies with ED Use

Strategy 12c **95%**
Psychiatric Emergency Services Linkage


Strategy 12b **77%**

Hospital Re-Entry Respite Beds

Strategy 3a **62%**
Supportive Housing


Top Three Strategies with Psychiatric Hospital Use

Strategy 16a **73%**
New Housing & Rental Subsidies


Strategy 12c **30%**
Psychiatric Emergency Services Linkage


Strategy 10b **28%**
Adult Crisis Diversion


Appendix V: Aggregate System Use by Relevant Strategies

All strategies (and sub-strategies) that track relevant system utilization over time as an outcome are first listed in strategy order in the pages which follow. For jail and detention use, the number of people eligible for analysis by time alone appears in the "Time Eligible" column. The number of people who had any system use in a given analysis period is shown in the "Use Eligible" column. The total number of bookings, admissions and/or days (as appropriate) for the year-long period prior to the start of MIDD services appears in subsequent columns, followed by aggregate measures for each post period studied. The percent change is calculated as: (Post measure minus Pre measure) divided by Pre measure. Rows marked in gray are subsets of data for which the combined totals appear directly above. Tables sorted on jail/detention booking reductions by age group begin on Page 62. Reductions in excess of the targeted reduction goals, as explained on Page 8, are highlighted in light green. Changes in emergency department use begin on Page 66, followed by psychiatric hospitalizations on Page 68. It is generally expected that as each sample grows with the passage of time and the addition of newly qualified cohorts, more strategies will achieve long-term reductions in system use that will meet the targets established in 2008.

Total Jail/Detention Bookings and Days in Each Post Period

First Post				Jail/Detention Bookings			Jail/Detention Days		
		Time Eligible	Use Eligible	Pre	Post 1	% Change	Pre	Post 1	% Change
1a-1a	Mental Health Treatment ¹	8,698	1,501	3,146	2,348	-25%	69,023	47,481	-31%
	Adults	7,395	1,416	3,025	2,246	-26%	67,543	45,772	-32%
	Youth ²	1,303	85	121	102	-16%	1,480	1,709	+15%
1a-2a	Outpatient SUD Treatment ³	10,015	4,889	8,733	5,751	-34%	160,819	107,858	-33%
	Adults	8,181	4,321	7,723	4,832	-37%	146,949	92,573	-37%
	Youth ²	1,834	568	1,010	919	-9%	13,870	15,285	+10%
1a-2b	Opiate SUD Treatment	2,084	757	1,313	1,092	-17%	24,913	19,811	-20%
1b	Outreach & Engagement	4,630	1,913	3,398	3,390	0%	53,308	57,501	+8%
1c	Emergency Room Intervention	16,181	4,519	7,541	8,355	+11%	123,671	146,438	+18%
	Harborview	11,493	3,441	5,912	6,264	+6%	101,883	112,613	+11%
	South County	4,688	1,078	1,629	2,091	+28%	21,788	33,825	+55%
1d	Crisis Next Day Appointments	2,830	703	947	975	+3%	23,882	18,533	-22%
3a	Supportive Housing	1,302	626	1,626	972	-40%	32,575	18,105	-44%
4c	School-Based Services	2,037	28	<10	50	+733%	39	783	+1,908%
5a	Juvenile Justice Assessments	2,049	1,340	1,965	3,168	+61%	21,141	57,152	+170%
6a	Wraparound	1,271	251	385	496	+29%	5,581	6,770	+21%
7b	Expand Youth Crisis Services	2,710	298	251	550	+119%	3,071	7,508	+144%
8a	Family Treatment Court	165	91	155	95	-39%	1,616	1,347	-17%
9a	Juvenile Drug Court	254	210	489	608	+24%	6,915	14,456	+109%
10b	Adult Crisis Diversion	3,464	1,156	1,778	2,315	+30%	25,937	43,433	+67%
11a	Increase Jail Liaison Capacity	700	578	1,535	988	-36%	24,923	26,747	+7%
11b-1	Seattle MH Court Expansion	823	777	2,192	1,432	-35%	30,389	37,157	+22%
11b-2	Regional Mental Health Court	563	450	1,025	752	-27%	25,230	18,232	-28%
12a-1	Jail Re-Entry Capacity	1,100	1,024	3,560	2,370	-33%	86,984	61,119	-30%
12a-2a	Education Classes at CCAP	970	803	1,942	1,487	-23%	32,373	40,612	+25%
12a-2b	CCAP Domestic Violence Education	1,465	1,125	2,564	2,106	-18%	36,019	56,407	+57%
12b	Hospital Re-Entry Respite Beds	913	387	783	598	-24%	10,618	13,195	+24%
12c	PES Linkage	462	267	662	566	-15%	8,884	9,465	+7%
12d	Behavior Modification Classes	584	509	1,139	866	-24%	19,168	28,313	+48%
15a	Adult Drug Court	1,223	1,072	2,525	2,074	-18%	29,822	72,502	+143%
16a	New Housing & Rental Subsidies	161	59	93	56	-40%	2,213	1,358	-39%

¹ Including Clubhouse participants

² Ages 9 to 18 at MIDD start

³ Including Detoxification Only clients

Second Post

Second Post

				Jail/Detention Bookings			Jail/Detention Days		
		Time Eligible	Use Eligible	Pre	Post 2	% Change	Pre	Post 2	% Change
1a-1a	Mental Health Treatment ¹	7,982	1,371	2,904	1,685	-42%	63,661	40,465	-36%
	Adults	6,825	1,283	2,787	1,595	-43%	62,198	38,460	-38%
	Youth ²	1,157	88	117	90	-23%	1,463	2,005	+37%
1a-2a	Outpatient SUD Treatment	8,764	4,295	7,761	4,142	-47%	143,051	90,414	-37%
	Adults	7,377	3,908	7,117	3,677	-48%	134,536	81,119	-40%
	Youth ²	1,387	387	644	465	-28%	8,515	9,295	+9%
1a-2b	Opiate SUD Treatment	1,930	696	1,227	811	-34%	22,787	14,770	-35%
1b	Outreach & Engagement	4,040	1,650	2,983	2,483	-17%	47,774	48,826	+2%
1c	Emergency Room Intervention	14,236	3,829	6,546	6,978	7%	108,884	116,528	+7%
	Harborview	10,189	2,946	5,216	4,522	-13%	90,940	89,663	-1%
	South County	4,047	883	1,330	1,456	9%	17,944	26,865	+50%
1d	Crisis Next Day Appointments	2,584	620	919	705	-23%	23,141	16,308	-30%
3a	Supportive Housing	1,081	521	1,440	715	-50%	28,599	13,889	-51%
4c	School-Based Services	1,164	28	5	61	+1120%	37	1,099	+2870%
5a	Juvenile Justice Assessments	1,629	1,012	1,751	1,650	-6%	19,900	34,591	+74%
6a	Wraparound	996	216	345	419	+21%	5,163	6,072	+18%
7b	Expand Youth Crisis Services	1,814	216	186	349	+88%	2,128	6,282	+195%
8a	Family Treatment Court	142	78	135	79	-41%	1,312	1,091	-17%
9a	Juvenile Drug Court	205	166	419	366	-13%	5,805	7,721	+33%
10b	Adult Crisis Diversion	1,819	555	919	927	+1%	14,112	19,382	+37%
11a	Increase Jail Liaison Capacity	687	565	1,501	865	-42%	24,397	22,513	-8%
11b-1	Seattle MH Court Expansion	561	528	1,590	827	-48%	20,923	23,801	+14%
11b-2	Regional Mental Health Court	396	302	698	514	-26%	10,848	13,150	+21%
12a-1	Jail Re-Entry Capacity	954	874	3,084	1,706	-45%	76,008	45,997	-39%
12a-2a	Education Classes at CCAP	829	675	1,665	966	-42%	28,979	23,763	-18%
12a-2b	CCAP Domestic Violence Education	1,106	846	1,995	1,229	-38%	28,295	28,609	+1%
12b	Hospital Re-Entry Respite Beds	641	257	531	303	-43%	7,471	7,349	-2%
12c	PES Linkage	415	231	597	406	-32%	7,845	8,213	+5%
12d	Behavior Modification Classes	494	420	990	561	-43%	16,486	17,065	+4%
15a	Adult Drug Court	976	826	2,021	1,256	-38%	23,886	26,096	+9%
16a	New Housing & Rental Subsidies	136	53	87	48	-45%	2,135	1,890	-11%

Third Post

Third Post

				Jail/Detention Bookings			Jail/Detention Days		
		Time Eligible	Use Eligible	Pre	Post 3	% Change	Pre	Post 3	% Change
1a-1a	Mental Health Treatment ¹	6,786	1,123	2,417	1,183	-52%	52,233	26,821	-49%
	Adults	5,774	1,045	2,319	1,092	-54%	50,994	25,439	-50%
	Youth ²	1,012	78	98	91	-7%	1,239	1,382	+11%
1a-2a	Outpatient SUD Treatment	7,582	3,659	6,581	3,198	-51%	123,302	64,998	-47%
	Adults	6,340	3,324	6,011	2,781	-54%	115,950	57,878	-50%
	Youth ²	1,242	335	570	417	-27%	7,352	7,120	-3%
1a-2b	Opiate SUD Treatment	1,653	591	1,020	550	-46%	18,983	9,385	-51%
1b	Outreach & Engagement	3,441	1,413	2,637	1,860	-29%	43,617	34,832	-20%
1c	Emergency Room Intervention	11,225	3,025	5,367	3,981	-25%	90,925	80,405	-12%
	Harborview	8,030	2,366	4,374	3,048	-30%	77,244	62,981	-18%
	South County	3,195	659	993	933	-6%	13,681	17,424	+27%
1d	Crisis Next Day Appointments	2,325	559	891	606	-32%	22,350	13,886	-38%
3a	Supportive Housing	910	457	1,268	508	-60%	25,856	11,631	-55%
4c	School-Based Services	97	0	0	0	0%	0	0	0%
5a	Juvenile Justice Assessments	825	600	1,318	852	-35%	16,410	18,340	+12%
6a	Wraparound	718	173	279	285	+2%	3,874	5,493	+42%
7b	Expand Youth Crisis Services	951	121	111	143	+29%	1,180	1,964	+66%
8a	Family Treatment Court	120	69	109	65	-40%	1,091	1,220	+12%
9a	Juvenile Drug Court	124	107	309	198	-36%	4,322	4,369	+1%
10b	Adult Crisis Diversion	290	100	184	140	-24%	3,024	3,427	+13%
11a	Increase Jail Liaison Capacity	614	489	1,331	707	-47%	21,569	16,564	-23%
11b-1	Seattle MH Court Expansion	267	248	736	267	-64%	9,184	7,794	-15%
11b-2	Regional Mental Health Court	242	176	417	235	-44%	7,209	7,132	-1%
12a-1	Jail Re-Entry Capacity	788	704	2,482	1,115	-55%	59,343	28,005	-53%
12a-2a	Education Classes at CCAP	661	522	1,312	754	-43%	23,783	15,038	-37%
12a-2b	CCAP Domestic Violence Education	809	599	1,497	796	-47%	21,690	16,129	-26%
12b	Hospital Re-Entry Respite Beds	297	116	231	141	-39%	3,290	3,289	0%
12c	PES Linkage	346	190	502	263	-48%	6,804	6,413	-6%
12d	Behavior Modification Classes	363	294	722	359	-50%	12,222	10,477	-14%
15a	Adult Drug Court	816	680	1,712	742	-57%	21,068	15,310	-27%
16a	New Housing & Rental Subsidies	122	48	84	31	-63%	2,101	887	-58%

¹ Including Clubhouse participants

² Ages 9 to 18 at MIDD start

Fourth Post

		Time Eligible	Use Eligible	Jail/Detention Bookings			Jail/Detention Days		
				Pre	Post 4	% Change	Pre	Post 4	% Change
1a-1a	Mental Health Treatment	4,429	715	1,537	616	-60%	33,387	14,482	-57%
	Adults	3,719	661	1,453	564	-61%	32,316	13,456	-58%
	Youth ¹	710	54	84	52	-38%	1,071	1,026	-4%
1a-2a	Outpatient SUD Treatment	6,223	2,985	5,436	2,244	-59%	101,288	46,175	-54%
	Adults	5,208	2,694	4,940	1,895	-62%	95,020	40,992	-57%
	Youth ¹	1,015	291	496	349	-30%	6,268	5,183	-17%
1a-2b	Opiate SUD Treatment	1,356	474	835	421	-50%	15,834	8,178	-48%
1b	Outreach & Engagement	2,686	1,067	2,054	1,202	-41%	34,552	22,013	-36%
1c	Emergency Room Intervention	7,346	2,082	3,878	2,522	-35%	65,099	45,860	-30%
	Harborview	5,441	1,676	3,280	1,977	-40%	57,075	37,091	-35%
	South County	1,905	406	598	545	-9%	8,024	8,769	+9%
1d	Crisis Next Day Appointments	2,121	513	851	498	-41%	21,805	10,805	-50%
3a	Supportive Housing	694	338	1,019	343	-66%	21,421	7,974	-63%
5a	Juvenile Justice Assessments	599	434	959	571	-40%	12,321	12,364	0%
6a	Wraparound	422	118	193	205	+6%	3,006	3,956	+32%
8a	Family Treatment Court	83	49	78	40	-49%	637	466	-27%
9a	Juvenile Drug Court	93	77	212	110	-48%	2,622	2,311	-12%
11a	Increase Jail Liaison Capacity	413	321	864	439	-49%	13,616	12,202	-10%
11b-2	Regional Mental Health Court	148	108	263	113	-57%	4,432	3,476	-22%
12a-1	Jail Re-Entry Capacity	590	518	1,757	682	-61%	44,256	16,908	-62%
12a-2a	Education Classes at CCAP	447	358	899	461	-49%	16,615	11,194	-33%
12a-2b	CCAP Domestic Violence Education	469	347	922	431	-53%	12,708	9,169	-28%
12c	PES Linkage	300	168	476	178	-63%	6,593	4,353	-34%
12d	Behavior Modification Classes	204	163	403	164	-59%	6,729	5,554	-17%
15a	Adult Drug Court	630	513	1,274	549	-57%	16,524	9,522	-42%
16a	New Housing & Rental Subsidies	108	40	83	19	-77%	2,099	555	-74%

Fifth Post

		Time Eligible	Use Eligible	Jail/Detention Bookings			Jail/Detention Days		
				Pre	Post 5	% Change	Pre	Post 5	% Change
1a-1a	Mental Health Treatment	3,519	546	1,156	497	-57%	24,630	13,572	-45%
	Adults	2,967	498	1,089	446	-59%	23,722	12,576	-47%
	Youth ¹	552	48	67	51	-24%	908	996	+10%
1a-2a	Outpatient SUD Treatment	4,692	2,186	3,986	1,648	-59%	71,415	35,229	-51%
	Adults	3,905	1,966	3,611	1,376	-62%	67,250	30,273	-55%
	Youth ¹	787	220	375	272	-27%	4,165	4,956	+19%
1a-2b	Opiate SUD Treatment	1,201	396	673	359	-47%	12,217	6,025	-51%
1b	Outreach & Engagement	1,798	631	1,178	694	-41%	20,636	12,843	-38%
1c	Emergency Room Intervention	4,304	1,266	2,522	1,575	-38%	41,139	33,145	-19%
	Harborview	3,548	1,097	2,301	1,321	-43%	37,689	28,318	-25%
	South County	756	169	221	254	+15%	3,450	4,827	+40%
1d	Crisis Next Day Appointments	1,750	407	723	382	-47%	18,824	8,818	-53%
3a	Supportive Housing	380	184	561	150	-73%	10,130	2,874	-72%
5a	Juvenile Justice Assessments	299	217	536	287	-46%	6,640	6,380	-4%
6a	Wraparound	237	72	101	95	-6%	2,095	2,014	-4%
8a	Family Treatment Court	53	26	43	17	-60%	484	237	-51%
9a	Juvenile Drug Court	62	50	143	98	-31%	1,927	2,124	+10%
11a	Increase Jail Liaison Capacity	267	196	545	220	-60%	8,333	5,925	-29%
12a-1	Jail Re-Entry Capacity	423	364	1,220	418	-66%	30,928	10,177	-67%
12a-2a	Education Classes at CCAP	215	152	385	167	-57%	7,568	3,769	-50%
12a-2b	CCAP Domestic Violence Education	269	192	543	206	-62%	7,352	4,730	-36%
12c	PES Linkage	226	126	390	138	-65%	5,452	3,712	-32%
12d	Behavior Modification Classes	94	75	162	42	-74%	2,943	1,087	-63%
15a	Adult Drug Court	425	345	874	359	-59%	11,840	6,653	-44%
16a	New Housing & Rental Subsidies	84	30	55	16	-71%	1,419	617	-57%

¹ Ages 9 to 18 at MIDD start

Adult Jail Use in Each Post Period Sorted on Booking Reductions

Separate targeted jail use reduction goals for adults and youth were established in 2008, going out five years beyond each individual's MIDD start date. For adults, an extra five percent reduction per year was added to account for overall jail use reductions throughout King County, as shown in the table below. In the first post period, reductions in excess of ten percent for adult jail bookings were achieved by 16 of the 20 strategies or sub-strategies (80%) intended to reduce jail utilization. These same strategies saw reductions greater than 25 percent in the second post period, and almost all had achieved 40 percent reductions by the third post period. Of the 17 strategies eligible for a fourth post analysis, nine (53%) had jail booking reductions of more than 55 percent. The lofty goal of achieving 70 percent jail reductions by the fifth post period was accomplished with fairly small sample sizes by three of the 16 strategies with data (19%), as shown on Page 64.

Targeted reductions in adult jail days were harder to achieve than booking reductions, due in part to the use of sanctioning and the imposition of longer jail sentences on individuals who re-offended. While treatment and housing strategies tended to achieve reductions in days that aligned with their booking reductions, therapeutic courts and diversion strategies often had to overcome steep initial increases in jail days before achieving desirable reductions. The one exception to this rule was Strategy 12a-1—Jail Re-Entry Capacity, where reductions in days often mirrored booking declines over time.

Adult Jail Bookings or Days			
Period	Incremental	Additional	Cumulative
Post 1	-5%	-5%	-10%
Post 2	-10%	-5%	-25%
Post 3	-10%	-5%	-40%
Post 4	-10%	-5%	-55%
Post 5	-10%	-5%	-70%

First Post

		Time Eligible	Use Eligible	Jail Bookings			Jail Days		
				Pre	Post 1	% Change	Pre	Post 1	% Change
3a	Supportive Housing	1,302	626	1,626	972	-40%	32,575	18,105	-44%
16a	New Housing & Rental Subsidies	161	59	93	56	-40%	2,213	1,358	-39%
8a	Family Treatment Court	165	91	155	95	-39%	1,616	1,347	-17%
1a-2a	Outpatient SUD Treatment	8,181	4,321	7,723	4,832	-37%	146,949	92,573	-37%
11a	Increase Jail Liaison Capacity	700	578	1,535	988	-36%	24,923	26,747	+7%
11b-1	Seattle MH Court Expansion	823	777	2,192	1,432	-35%	30,389	37,157	+22%
12a-1	Jail Re-Entry Capacity	1,100	1,024	3,560	2,370	-33%	86,984	61,119	-30%
11b-2	Regional Mental Health Court	563	450	1,025	752	-27%	25,230	18,232	-28%
1a-1a	Mental Health Treatment	7,395	1,416	3,025	2,246	-26%	67,543	45,772	-32%
12b	Hospital Re-Entry Respite Beds	913	387	783	598	-24%	10,618	13,195	+24%
12d	Behavior Modification Classes	584	509	1,139	866	-24%	19,168	28,313	+48%
12a-2a	Education Classes at CCAP	970	803	1,942	1,487	-23%	32,373	40,612	+25%
12a-2b	CCAP Domestic Violence Education	1,465	1,125	2,564	2,106	-18%	36,019	56,407	+57%
15a	Adult Drug Court	1,223	1,072	2,525	2,074	-18%	29,822	72,502	+143%
1a-2b	Opiate SUD Treatment	2,084	757	1,313	1,092	-17%	24,913	19,811	-20%
12c	PES Linkage	462	267	662	566	-15%	8,884	9,465	+7%
1b	Outreach & Engagement	4,630	1,913	3,398	3,390	+0%	53,308	57,501	+8%
1d	Crisis Next Day Appointments	2,830	703	947	975	+3%	23,882	18,533	-22%
1c	Emergency Room Intervention	16,181	4,519	7,541	8,355	+11%	123,671	146,438	+18%
10b	Adult Crisis Diversion	3,464	1,156	1,778	2,315	+30%	25,937	43,433	+67%

Second Post

		Time Eligible	Use Eligible	Jail Bookings			Jail Days		
				Pre	Post 2	% Change	Pre	Post 2	% Change
3a	Supportive Housing	1,081	521	1,440	715	-50%	28,599	13,889	-51%
1a-2a	Outpatient SUD Treatment	7,377	3,908	7,117	3,677	-48%	134,536	81,119	-40%
11b-1	Seattle MH Court Expansion	561	528	1,590	827	-48%	20,923	23,801	+14%
12a-1	Jail Re-Entry Capacity	954	874	3,084	1,706	-45%	76,008	45,997	-39%
16a	New Housing & Rental Subsidies	136	53	87	48	-45%	2,135	1,890	-11%
1a-1a	Mental Health Treatment	6,825	1,283	2,787	1,595	-43%	62,198	38,460	-38%
12b	Hospital Re-Entry Respite Beds	641	257	531	303	-43%	7,471	7,349	-2%
12d	Behavior Modification Classes	494	420	990	561	-43%	16,486	17,065	+4%
11a	Increase Jail Liaison Capacity	687	565	1,501	865	-42%	24,397	22,513	-8%
12a-2a	Education Classes at CCAP	829	675	1,665	966	-42%	28,979	23,763	-18%
8a	Family Treatment Court	142	78	135	79	-41%	1,312	1,091	-17%
12a-2b	CCAP Domestic Violence Education	1,106	846	1,995	1,229	-38%	28,295	28,609	+1%
15a	Adult Drug Court	976	826	2,021	1,256	-38%	23,886	26,096	+9%
1a-2b	Opiate SUD Treatment	1,930	696	1,227	811	-34%	22,787	14,770	-35%
12c	PES Linkage	415	231	597	406	-32%	7,845	8,213	+5%
11b-2	Regional Mental Health Court	396	302	698	514	-26%	10,848	13,150	+21%
1d	Crisis Next Day Appointments	2,584	620	919	705	-23%	23,141	16,308	-30%
1b	Outreach & Engagement	4,040	1,650	2,983	2,483	-17%	47,774	48,826	+2%
10b	Adult Crisis Diversion	1,819	555	919	927	+1%	14,112	19,382	+37%
1c	Emergency Room Intervention	14,236	3,829	6,546	6,978	+7%	108,884	116,528	+7%

Third Post

		Time Eligible	Use Eligible	Jail Bookings			Jail Days		
				Pre	Post 3	% Change	Pre	Post 3	% Change
11b-1	Seattle MH Court Expansion	267	248	736	267	-64%	9,184	7,794	-15%
16a	New Housing & Rental Subsidies	122	48	84	31	-63%	2,101	887	-58%
3a	Supportive Housing	910	457	1,268	508	-60%	25,856	11,631	-55%
15a	Adult Drug Court	816	680	1,712	742	-57%	21,068	15,310	-27%
12a-1	Jail Re-Entry Capacity	788	704	2,482	1,115	-55%	59,343	28,005	-53%
1a-1a	Mental Health Treatment	5,774	1,045	2,319	1,092	-54%	50,994	25,439	-50%
1a-2a	Outpatient SUD Treatment	6,340	3,324	6,011	2,781	-54%	115,950	57,878	-50%
12d	Behavior Modification Classes	363	294	722	359	-50%	12,222	10,477	-14%
12c	PES Linkage	346	190	502	263	-48%	6,804	6,413	-6%
11a	Increase Jail Liaison Capacity	614	489	1,331	707	-47%	21,569	16,564	-23%
12a-2b	CCAP Domestic Violence Education	809	599	1,497	796	-47%	21,690	16,129	-26%
1a-2b	Opiate SUD Treatment	1,653	591	1,020	550	-46%	18,983	9,385	-51%
11b-2	Regional Mental Health Court	242	176	417	235	-44%	7,209	7,132	-1%
12a-2a	Education Classes at CCAP	661	522	1,312	754	-43%	23,783	15,038	-37%
8a	Family Treatment Court	120	69	109	65	-40%	1,091	1,220	+12%
12b	Hospital Re-Entry Respite Beds	297	116	231	141	-39%	3,290	3,289	0%
1d	Crisis Next Day Appointments	2,325	559	891	606	-32%	22,350	13,886	-38%
1b	Outreach & Engagement	3,441	1,413	2,637	1,860	-29%	43,617	34,832	-20%
1c	Emergency Room Intervention	11,225	3,025	5,367	3,981	-25%	90,925	80,405	-12%
10b	Adult Crisis Diversion	290	100	184	140	-24%	3,024	3,427	+13%

Fourth Post

				Jail Bookings			Jail Days		
		Time Eligible	Use Eligible	Pre	Post 4	% Change	Pre	Post 4	% Change
16a	New Housing & Rental Subsidies	108	40	83	19	-77%	2,099	555	-74%
3a	Supportive Housing	694	338	1,019	343	-66%	21,421	7,974	-63%
12c	PES Linkage	300	168	476	178	-63%	6,593	4,353	-34%
1a-2a	Outpatient SUD Treatment	5,208	2,694	4,940	1,895	-62%	95,020	40,992	-57%
1a-1a	Mental Health Treatment	3,719	661	1,453	564	-61%	32,316	13,456	-58%
12a-1	Jail Re-Entry Capacity	590	518	1,757	682	-61%	44,256	16,908	-62%
12d	Behavior Modification Classes	204	163	403	164	-59%	6,729	5,554	-17%
11b-2	Regional Mental Health Court	148	108	263	113	-57%	4,432	3,476	-22%
15a	Adult Drug Court	630	513	1,274	549	-57%	16,524	9,522	-42%
12a-2b	CCAP Domestic Violence Education	469	347	922	431	-53%	12,708	9,169	-28%
1a-2b	Opiate SUD Treatment	1,356	474	835	421	-50%	15,834	8,178	-48%
8a	Family Treatment Court	83	49	78	40	-49%	637	466	-27%
11a	Increase Jail Liaison Capacity	413	321	864	439	-49%	13,616	12,202	-10%
12a-2a	Education Classes at CCAP	447	358	899	461	-49%	16,615	11,194	-33%
1b	Outreach & Engagement	2,686	1,067	2,054	1,202	-41%	34,552	22,013	-36%
1d	Crisis Next Day Appointments	2,121	513	851	498	-41%	21,805	10,805	-50%
1c	Emergency Room Intervention	7,346	2,082	3,878	2,522	-35%	65,099	45,860	-30%

Fifth Post

				Jail Bookings			Jail Days		
		Time Eligible	Use Eligible	Pre	Post 5	% Change	Pre	Post 5	% Change
12d	Behavior Modification Classes	94	75	162	42	-74%	2,943	1,087	-63%
3a	Supportive Housing	380	184	561	150	-73%	10,130	2,874	-72%
16a	New Housing & Rental Subsidies	84	30	55	16	-71%	1,419	617	-57%
12a-1	Jail Re-Entry Capacity	423	364	1,220	418	-66%	30,928	10,177	-67%
12c	PES Linkage	226	126	390	138	-65%	5,452	3,712	-32%
1a-2a	Outpatient SUD Treatment	3,905	1,966	3,611	1,376	-62%	67,250	30,273	-55%
12a-2b	CCAP Domestic Violence Education	269	192	543	206	-62%	7,352	4,730	-36%
8a	Family Treatment Court	53	26	43	17	-60%	484	237	-51%
11a	Increase Jail Liaison Capacity	267	196	545	220	-60%	8,333	5,925	-29%
1a-1a	Mental Health Treatment	2,967	498	1,089	446	-59%	23,722	12,576	-47%
15a	Adult Drug Court	425	345	874	359	-59%	11,840	6,653	-44%
12a-2a	Education Classes at CCAP	215	152	385	167	-57%	7,568	3,769	-50%
1a-2b	Opiate SUD Treatment	1,201	396	673	359	-47%	12,217	6,025	-51%
1d	Crisis Next Day Appointments	1,750	407	723	382	-47%	18,824	8,818	-53%
1b	Outreach & Engagement	1,798	631	1,178	694	-41%	20,636	12,843	-38%
1c	Emergency Room Intervention	4,304	1,266	2,522	1,575	-38%	41,139	33,145	-19%

Youth Detention Use in Each Post Period Sorted on Booking Reductions

Prior to MIDD implementation in 2008, it was expected that certain strategies could bring about annual reductions of 10 percent in youth detention bookings or days, ultimately cutting such measures in half by the fifth post period. With few exceptions, these targeted reductions were not realized. Possible reasons for this include: 1) detentions prior to MIDD services, against which subsequent use was compared, were rare or few for younger clients, 2) as youth aged and gained independence, their opportunities to become involved with the juvenile justice and criminal justice systems increased, and 3) longer detentions may have been imposed early on to impact behavioral changes over the long term.

Youth Detention Bookings or Days

Period	Incremental	Cumulative
Post 1	-10%	-10%
Post 2	-10%	-20%
Post 3	-10%	-30%
Post 4	-10%	-40%
Post 5	-10%	-50%

First Post

First Post

		Time Eligible	Use Eligible	Detention Bookings			Detention Days		
				Pre	Post 1	% Change	Pre	Post 1	% Change
1a-1a	Mental Health Treatment	1,303	85	121	102	-16%	1,480	1,709	+15%
1a-2a	Outpatient SUD Treatment	1,834	568	1,010	919	-9%	13,870	15,285	+10%
9a	Juvenile Drug Court	254	210	489	608	+24%	6,915	14,456	+109%
6a	Wraparound	1,271	251	385	496	+29%	5,581	6,770	+21%
5a	Juvenile Justice Assessments	2,049	1,340	1,965	3,168	+61%	21,141	57,152	+170%
7b	Expand Youth Crisis Services	2,710	298	251	550	+119%	3,071	7,508	+144%
4c	School-Based Services	2,037	28	<10	50	+733%	39	783	+1,908%

Second Post

Second Post

		Time Eligible	Use Eligible	Detention Bookings			Detention Days		
				Pre	Post 2	% Change	Pre	Post 2	% Change
1a-2a	Outpatient SUD Treatment	1,387	387	644	465	-28%	8,515	9,295	+9%
1a-1a	Mental Health Treatment	1,157	88	117	90	-23%	1,463	2,005	+37%
9a	Juvenile Drug Court	205	166	419	366	-13%	5,805	7,721	+33%
5a	Juvenile Justice Assessments	1,629	1,012	1,751	1,650	-6%	19,900	34,591	+74%
6a	Wraparound	996	216	345	419	+21%	5,163	6,072	+18%
7b	Expand Youth Crisis Services	1,814	216	186	349	+88%	2,128	6,282	+195%
4c	School-Based Services	1,164	28	5	61	+1120%	37	1,099	+2870%

		Time Eligible	Use Eligible	Detention Bookings			Detention Days		
				Pre	Post 3	% Change	Pre	Post 3	% Change
9a	Juvenile Drug Court	124	107	309	198	-36%	4,322	4,369	+1%
5a	Juvenile Justice Assessments	825	600	1,318	852	-35%	16,410	18,340	+12%
1a-2a	Outpatient SUD Treatment	1,242	335	570	417	-27%	7,352	7,120	-3%
1a-1a	Mental Health Treatment	1,012	78	98	91	-7%	1,239	1,382	+11%
4c	School-Based Services	97	0	0	0	0%	0	0	0%
6a	Wraparound	718	173	279	285	+2%	3,874	5,493	+42%
7b	Expand Youth Crisis Services	951	121	111	143	+29%	1,180	1,964	+66%

Fourth Post

Fourth Post		Time Eligible	Use Eligible	Detention Bookings			Detention Days		
				Pre	Post 4	% Change	Pre	Post 4	% Change
9a	Juvenile Drug Court	93	77	212	110	-48%	2,622	2,311	-12%
5a	Juvenile Justice Assessments	599	434	959	571	-40%	12,321	12,364	0%
1a-1a	Mental Health Treatment	710	54	84	52	-38%	1,071	1,026	-4%
1a-2a	Outpatient SUD Treatment	1,015	291	496	349	-30%	6,268	5,183	-17%
6a	Wraparound	422	118	193	205	+6%	3,006	3,956	+32%

Fifth Post

Fifth Post				Detention Bookings			Detention Days		
				Pre	Post 5	% Change	Pre	Post 5	% Change
5a	Juvenile Justice Assessments	299	217	536	287	-46%	6,640	6,380	-4%
9a	Juvenile Drug Court	62	50	143	98	-31%	1,927	2,124	+10%
1a-2a	Outpatient SUD Treatment	787	220	375	272	-27%	4,165	4,956	+19%
1a-1a	Mental Health Treatment	552	48	67	51	-24%	908	996	+10%
6a	Wraparound	237	72	101	95	-6%	2,095	2,014	-4%

Total Harborview Emergency Department Admissions in Each Post Period

Targeted reductions in the number of admissions to Harborview Medical Center's emergency department (ED) were set in 2008 for MIDD strategies expected to have an impact on ED utilization, as shown at right. The number of people included in the analysis for each post period is displayed in the first table below, followed by ED use changes over time in strategy order, then in order of best reductions for the second post period where 10 of 14 strategies (71%) exceeded the reduction targets. The only strategy that met these targets in every post period was Strategy 12c—Psychiatric Emergency Services (PES) Linkage.

Harborview ED Admissions				
Period	Adults		Youth	
	Incremental	Cumulative	Incremental	Cumulative
Post 1	-5%	-5%	-10%	-10%
Post 2	-14%	-19%	-10%	-20%
Post 3	-13%	-32%	-10%	-30%
Post 4	-13%	-45%	-10%	-40%
Post 5	-15%	-60%	-10%	-50%

		Eligible by Time and Use				
		Post 1	Post 2	Post 3	Post 4	Post 5
1a-1a	Mental Health Treatment ¹	2,049	1,822	1,487	1,000	747
	Adults	2,010	1,781	1,449	967	726
	Youth ²	39	41	38	33	21
1a-2a	Outpatient SUD Treatment	1,908	1,659	1,405	1,153	879
	Adults	1,814	1,574	1,335	1,085	833
	Youth ²	94	85	70	68	46
1a-2b	Opiate SUD Treatment	652	597	527	456	381
1b	Outreach & Engagement	2,147	1,731	1,470	1,124	706
1c	Emergency Room Intervention	9,086	6,631	5,163	3,489	2,219
	Harborview	8,142	5,957	4,640	3,165	2,049
	South County	944	674	523	324	170
1d	Crisis Next Day Appointments	1,505	1,319	1,182	1,069	858
1g	Older Adults Prevention ³	1,247	1,049	791	587	341
1h	Older Adults Crisis & Svc Linkage	261	164	121	96	53
3a	Supportive Housing	854	694	580	416	209
7b	Expand Youth Crisis Services	215	131	84	N/A	N/A
10b	Adult Crisis Diversion	1,988	892	162	N/A	N/A
12b	Hospital Re-Entry Respite Beds	754	471	219	N/A	N/A
12c	PES Linkage	433	390	324	286	217
16a	New Housing & Rental Subsidies	90	74	68	57	46

Top Three Strategies Reducing ED Use at Harborview Over the Long Term

Strategy 12c
Psychiatric
Emergency
Services
Linkage



Strategy 1d
Crisis Next Day
Appointments

Strategy 1h
Older Adults
Crisis &
Service
Linkage



¹ Including Clubhouse participants

² Ages 9 to 18 at MIDD start

³ Limited to those with services beyond

Strategy Order

		Pre	Post 1	% Change	Pre	Post 2	% Change	Pre	Post 3	% Change	Pre	Post 4	% Change	Pre	Post 5	% Change
1a-1a	Mental Health Treatment	3,924	3,279	-16%	3,447	2,415	-30%	2,791	1,954	-30%	1,809	1,187	-34%	1,347	867	-36%
	Adults	3,903	3,249	-17%	3,426	2,387	-30%	2,772	1,918	-31%	1,791	1,161	-35%	1,331	859	-35%
	Youth	21	30	+43%	21	28	+33%	19	36	+89%	18	26	+44%	16	8	-50%
1a-2a	Outpatient SUD Treatment	3,562	2,930	-18%	3,036	2,266	-25%	2,532	2,049	-19%	2,079	1,455	-30%	1,661	1,135	-32%
	Adults	3,490	2,866	-18%	2,977	2,197	-26%	2,488	1,987	-20%	2,039	1,399	-31%	1,627	1,099	-32%
	Youth	72	64	-11%	59	69	+17%	44	62	+40%	40	56	+40%	34	36	+6%
1a-2b	Opiate SUD Treatment	1,149	1,253	+18%	1,065	1,091	+2%	890	805	-10%	740	790	+7%	641	620	-3%
1b	Outreach & Engagement	5,262	6,222	+9%	4,260	4,128	-3%	3,678	3,489	-5%	2,687	2,430	-10%	1,697	1,521	-10%
1c	Emergency Room Intervention	17,127	25,074	+46%	14,937	12,539	-16%	12,103	9,393	-22%	8,869	6,479	-27%	5,971	3,801	-36%
	Harborview	15,995	23,027	+44%	14,074	11,281	-20%	11,412	8,378	-27%	8,362	5,813	-30%	5,698	3,459	-39%
	South County	1,132	2,047	+81%	863	1,258	+46%	691	1,015	+47%	507	666	+31%	273	342	+25%
1d	Crisis Next Day Appointments	2,609	2,675	+3%	2,448	1,420	-42%	2,292	1,186	-48%	2,146	882	-59%	1,785	674	-62%
1g	Older Adults Prevention	2,152	1,999	-7%	1,741	1,353	-22%	1,277	1,132	-11%	978	795	-19%	589	414	-30%
1h	Older Adults Crisis & Svc Linkage	430	486	+13%	284	186	-35%	211	65	-69%	175	41	-77%	99	10	-90%
3a	Supportive Housing	4,309	2,722	-37%	3,148	1,734	-45%	2,495	1,489	-40%	1,766	1,036	-41%	780	535	-31%
7b	Expand Youth Crisis Services	150	171	+14%	109	78	-28%	58	64	+10%	N/A	N/A	N/A	N/A	N/A	N/A
10b	Adult Crisis Diversion	5,210	7,854	+51%	3,094	2,424	-22%	693	496	-28%	N/A	N/A	N/A	N/A	N/A	N/A
12b	Hospital Re-Entry Respite Beds	2,741	4,021	+47%	1,794	1,564	-13%	842	586	-30%	N/A	N/A	N/A	N/A	N/A	N/A
12c	PES Linkage	5,819	4,469	-23%	4,959	2,030	-59%	3,638	1,585	-56%	3,125	1,339	-57%	2,517	809	-68%
16a	New Housing & Rental Subsidies	182	115	-37%	131	79	-40%	120	70	-42%	104	53	-49%	86	53	-38%

Best Reductions Order

		Pre	Post 1	% Change	Pre	Post 2	% Change	Pre	Post 3	% Change	Pre	Post 4	% Change	Pre	Post 5	% Change
12c	PES Linkage	5,819	4,469	-23%	4,959	2,030	-59%	3,638	1,585	-56%	3,125	1,339	-57%	2,517	809	-68%
3a	Supportive Housing	4,309	2,722	-37%	3,148	1,734	-45%	2,495	1,489	-40%	1,766	1,036	-41%	780	535	-31%
1d	Crisis Next Day Appointments	2,609	2,675	+3%	2,448	1,420	-42%	2,292	1,186	-48%	2,146	882	-59%	1,785	674	-62%
16a	New Housing & Rental Subsidies	182	115	-37%	131	79	-40%	120	70	-42%	104	53	-49%	86	53	-38%
1h	Older Adults Crisis & Svc Linkage	430	486	+13%	284	186	-35%	211	65	-69%	175	41	-77%	99	10	-90%
1a-1a	Mental Health Treatment	3,924	3,279	-16%	3,447	2,415	-30%	2,791	1,954	-30%	1,809	1,187	-34%	1,347	867	-36%
7b	Expand Youth Crisis Services	150	171	+14%	109	78	-28%	58	64	+10%	N/A	N/A	N/A	N/A	N/A	N/A
1a-2a	Outpatient SUD Treatment	3,562	2,930	-18%	3,036	2,266	-25%	2,532	2,049	-19%	2,079	1,455	-30%	1,661	1,135	-32%
1g	Older Adults Prevention	2,152	1,999	-7%	1,741	1,353	-22%	1,277	1,132	-11%	978	795	-19%	589	414	-30%
10b	Adult Crisis Diversion	5,210	7,854	+51%	3,094	2,424	-22%	693	496	-28%	N/A	N/A	N/A	N/A	N/A	N/A
1c	Emergency Room Intervention	17,127	25,074	+46%	14,937	12,539	-16%	12,103	9,393	-22%	8,869	6,479	-27%	5,971	3,801	-36%
12b	Hospital Re-Entry Respite Beds	2,741	4,021	+47%	1,794	1,564	-13%	842	586	-30%	N/A	N/A	N/A	N/A	N/A	N/A
1b	Outreach & Engagement	5,262	6,222	+9%	4,260	4,128	-3%	3,678	3,489	-5%	2,687	2,430	-10%	1,697	1,521	-10%
1a-2b	Opiate SUD Treatment	1,149	1,253	+18%	1,065	1,091	+2%	890	805	-10%	740	790	+7%	641	620	-3%

Statewide Emergency Department Admissions Using Small Sample Comparisons

For the first time since MIDD began, information on emergency department (ED) use throughout the State of Washington became available for purchase. Budget considerations restricted the strategies for which data were sought and the size of samples submitted for matching purposes. Recent cohorts representative of individuals served in ten different MIDD strategies were chosen to pilot the use of this new ED data source (as shown in the table below). As expected, the statewide incidence of ED admissions was higher than the incidence of use found for each strategy using only Harborview data, because all King County hospitals contribute information to the source. Where the incidence rates were similar, people in these strategies are more likely to utilize Harborview than other EDs. Where the rates differ markedly, it is essential to consider ED use beyond Harborview in order to fully understand the relationship between participation in MIDD strategies and overall reductions in ED use.

Sample Characteristics

		Earliest Pre Date	Last Post 1 Date	Small Sample N ¹	ED Use Found	Incidence in Statewide Data Set (Sample Cohort)	Incidence in Harborview Data Set (All Cohorts)
1a-1a	Mental Health Treatment	10/2012	3/2015	410	235	57%	23%
1a-2a	Outpatient SUD Treatment	10/2012	3/2015	460	219	48%	20%
1a-2b	Opiate SUD Treatment	10/2012	3/2015	88	57	65%	31%
1b	Outreach & Engagement	7/2012	12/2014	371	200	54%	46%
1c	Emergency Room Intervention	1/2013	6/2015	818	626	77%	56%
	Harborview	1/2013	6/2015	511	403	79%	71%
	South County	1/2013	6/2015	307	223	73%	20%
1g	Older Adults Prevention ²	7/2012	12/2014	280	155	55%	30%
3a	Supportive Housing	7/2012	12/2014	76	62	82%	66%
7b	Expand Youth Crisis Services	10/2012	3/2015	487	104	21%	8%
10b	Adult Crisis Diversion	10/2012	3/2015	812	536	66%	57%
12b	Hospital Re-Entry Respite Beds	10/2012	3/2015	146	122	84%	83%

¹ Data were requested for cohort(s) most representative of entire sample for each strategy

² Limited to those with services beyond screening

Using the new data source only, which provides information on both Harborview and non-Harborview EDs, first post period reductions in excess of five percent are highlighted in light green below. The strategies that met the reduction targets here had also met those targets using only the Harborview data source, as shown on Page 66. The one exception to this finding was for Strategy 1a-2b—Opiate Substance Use Disorder Treatment, which showed a short-term increase in admissions using the Harborview data source (+18%), but a decrease (-24%) using a smaller sample and the new data source. In general, if ED use increased over time at Harborview, it tended to increase at other hospitals within the state, too. An exception to this was for Strategy 1b—Outreach & Engagement, where increased use of Harborview's ED was somewhat offset by a reduction in use at other EDs.

New Data Source Only

		Harborview ED			Non-Harborview EDs			Combined		
		Pre	Post 1	% Change	Pre	Post 1	% Change	Pre	Post 1	% Change
1a-1a	Mental Health Treatment	266	207	-22%	545	478	-12%	811	685	-16%
1a-2a	Outpatient SUD Treatment	235	166	-29%	364	364	0%	599	530	-12%
1a-2b	Opiate SUD Treatment	58	44	-24%	134	99	-26%	192	143	-26%
1b	Outreach & Engagement	503	566	+13%	622	583	-6%	1,125	1,149	+2%
1c	Emergency Room Intervention	873	1,301	+49%	1,885	2,433	+29%	2,758	3,734	+35%
	Harborview	771	1,103	+43%	1,081	1,295	+20%	1,852	2,398	+29%
	South County	102	198	+94%	804	1,138	+42%	906	1,336	+47%
1g	Older Adults Prevention ²	99	76	-23%	197	203	+3%	296	279	-6%
3a	Supportive Housing	283	255	-10%	220	179	-19%	503	434	-14%
7b	Expand Youth Crisis Services	5	12	+140%	140	243	+74%	145	255	+76%
10b	Adult Crisis Diversion	773	1,346	+74%	2,425	2,951	+22%	3,198	4,297	+34%
12b	Hospital Re-Entry Respite Beds	425	528	+24%	390	353	-9%	815	881	+8%

To test the reliability of the new data source, ED use counts for individuals in the small sample request were compared to counts for those same people using the Harborview data source. For 64 percent of the matched cases, both ED data sources returned identical Harborview admission counts. Where differences existed, the Harborview source had reported ED admissions that the new source did not (29%), while in the remaining cases (7%), the new source reported Harborview ED admissions that the Harborview source did not. The identification criteria for matching requested individuals with their ED data may have led to the noted discrepancies.

Total Psychiatric Hospital Admissions and Days in Each Post Period

The targeted reduction goals for psychiatric hospitalizations as determined in 2008 are shown separately for adults and youth at right. In the first post period, three of 10 strategies (30%) were able to achieve reductions in both admissions and days greater than the 10 percent goal. By the third post analysis, six strategies plus the adult portion of Strategy 1a-1a—Mental Health Treatment showed reductions in admissions in excess of the goal for both adults (-26%) or youth (-30%). The sample reaching the greatest reductions (-86% by Post 5) in the number of combined days spent in community inpatient psychiatric hospitals and Western State Hospital was Strategy 16a—New Housing & Rental Subsidies, as shown on Page 69.

Psychiatric Hospital Admissions or Days

Period	Adults		Youth	
	Incremental	Cumulative	Incremental	Cumulative
Post 1	-10%	-10%	-10%	-10%
Post 2	-8%	-18%	-10%	-20%
Post 3	-8%	-26%	-10%	-30%
Post 4	-7%	-33%	-10%	-40%
Post 5	-7%	-40%	-10%	-50%

First Post

First Post				Psychiatric Hospital Admits			Psychiatric Hospital Days		
				Pre	Post 1	% Change	Pre	Post 1	% Change
1a-1a	Mental Health Treatment ¹	8,900	1,255	2,262	1,280	-43%	35,166	20,512	-42%
	Adults	7,395	1,205	2,210	1,245	-44%	34,518	20,090	-42%
	Youth ²	1,505	50	52	35	-33%	648	422	-35%
1b	Outreach & Engagement	4,630	240	242	293	+21%	3,318	3,780	+14%
1d	Crisis Next Day Appointments	2,830	514	438	623	+42%	5,450	7,677	+41%
1h	Older Adults Crisis & Svc Linkage	2,205	193	63	323	+413%	698	5,873	+741%
3a	Supportive Housing	1,302	273	665	341	-49%	15,633	7,263	-54%
7b	Expand Youth Crisis Services	2,710	467	168	643	+283%	1,670	8,497	+409%
10b	Adult Crisis Diversion	3,464	1,115	1,381	2,588	+87%	18,340	38,360	+109%
12b	Hospital Re-Entry Respite Beds	913	82	124	141	+14%	1,384	1,577	+14%
12c	PES Linkage	462	163	288	356	+24%	4,264	5,221	+22%
16a	New Housing & Rental Subsidies	161	126	415	130	-69%	11,565	2,864	-75%

¹ Including Clubhouse participants

² Ages 0 to 18 at MIDD start

Second Post

Second Post

				Psychiatric Hospital Admits			Psychiatric Hospital Days		
		Time Eligible	Use Eligible	Pre	Post 2	% Change	Pre	Post 2	% Change
1a-1a	Mental Health Treatment ¹	8,162	1,100	1,952	899	-54%	29,369	17,791	-39%
	Adults	6,827	1,053	1,905	863	-55%	28,787	16,917	-41%
	Youth ²	1,335	47	47	36	-23%	582	874	+50%
1b	Outreach & Engagement	4,040	194	208	232	+12%	3,038	3,143	+3%
1d	Crisis Next Day Appointments	2,584	376	418	373	-11%	5,253	5,400	+3%
1h	Older Adults Crisis & Svc Linkage	1,838	78	53	107	+102%	619	3,664	+492%
3a	Supportive Housing	1,081	241	536	322	-40%	13,836	7,774	-44%
7b	Expand Youth Crisis Services	1,814	148	139	121	-13%	1,287	1,629	+27%
10b	Adult Crisis Diversion	1,819	453	789	752	-5%	11,566	14,614	+26%
12b	Hospital Re-Entry Respite Beds	641	54	82	69	-16%	1,005	1,066	+6%
12c	PES Linkage	415	125	239	155	-35%	3,912	2,993	-23%
16a	New Housing & Rental Subsidies	136	101	342	123	-64%	9,935	2,574	-74%

Third Post

Third Post

				Psychiatric Hospital Admits			Psychiatric Hospital Days		
		Time Eligible	Use Eligible	Pre	Post 3	% Change	Pre	Post 3	% Change
1a-1a	Mental Health Treatment ¹	6,806	881	1,485	771	-48%	23,536	17,684	-25%
	Adults	5,632	383	1,441	739	-49%	22,976	16,800	-27%
	Youth ²	1,174	43	44	32	-27%	560	884	+58%
1b	Outreach & Engagement	3,441	162	180	175	-3%	2,532	3,020	+19%
1d	Crisis Next Day Appointments	2,325	324	390	274	-30%	4,908	4,692	-4%
1h	Older Adults Crisis & Svc Linkage	1,447	42	32	47	+47%	463	1,648	+256%
3a	Supportive Housing	910	188	384	274	-29%	10,795	6,982	-35%
7b	Expand Youth Crisis Services	951	88	90	60	-33%	899	1,347	+50%
10b	Adult Crisis Diversion	290	78	155	142	-8%	2,224	2,911	+31%
12b	Hospital Re-Entry Respite Beds	297	26	36	11	-69%	340	411	+30%
12c	PES Linkage	346	100	193	74	-62%	3,328	2,000	-40%
16a	New Housing & Rental Subsidies	122	90	285	106	-63%	8,727	2,417	-72%

Fourth Post

				Psychiatric Hospital Admits			Psychiatric Hospital Days		
		Time Eligible	Use Eligible	Pre	Post 4	% Change	Pre	Post 4	% Change
1a-1a	Mental Health Treatment	4,547	568	919	506	-45%	15,371	12,723	-17%
	Adults	3,719	538	886	481	-46%	14,930	12,154	-19%
	Youth ²	828	30	33	25	-24%	441	569	+29%
1b	Outreach & Engagement	2,686	124	134	134	0%	1,978	2,164	+9%
1d	Crisis Next Day Appointments	2,121	269	352	220	-38%	4,630	4,640	0%
1h	Older Adults Crisis & Svc Linkage	1,145	25	15	33	+120%	230	827	+260%
3a	Supportive Housing	694	131	369	189	-30%	7,552	6,804	-10%
12c	PES Linkage	300	82	172	87	-49%	2,988	2,216	-29%
16a	New Housing & Rental Subsidies	108	76	238	55	-77%	7,755	1,403	-82%

Fifth Post

				Psychiatric Hospital Admits			Psychiatric Hospital Days		
		Time Eligible	Use Eligible	Pre	Post 5	% Change	Pre	Post 5	% Change
1a-1a	Mental Health Treatment	3,623	425	677	361	-47%	11,149	8,922	-20%
	Adults	2,971	400	651	342	-47%	10,786	8,383	-22%
	Youth ²	652	25	26	19	-27%	363	539	+60%
1b	Outreach & Engagement	1,798	60	78	49	-37%	1,208	1,166	-3%
1d	Crisis Next Day Appointments	1,750	218	276	157	-43%	3,938	3,782	-4%
1h	Older Adults Crisis & Svc Linkage	754	<10	<10	<10	-63%	163	94	-42%
3a	Supportive Housing	380	73	132	118	-11%	4,231	4,546	+7%
12c	PES Linkage	226	65	139	73	-47%	2,547	2,338	-8%
16a	New Housing & Rental Subsidies	84	57	163	38	-77%	5,515	756	-86%

March 28, 2016

The Honorable Joe McDermott
Chair, King County Council
Room 1200
C O U R T H O U S E

Dear Councilmember McDermott:

This letter transmits the Mental Illness and Drug Dependency (MIDD) Eighth Annual Report covering the period of October 1, 2014, through September 30, 2015, for Council acceptance, per King County Ordinances 15949, 16261 and 16262. This report provides an overview of the implementation of the programs and services supported with the one-tenth of one percent sales tax revenues approved by the King County Council to improve access to mental health and substance abuse treatment, and therapeutic court services for people in need.

In 2010, King County approved the King County Strategic Plan. Two of the goals of the plan are to “support safe communities and accessible justice systems for all” and “promote opportunities for all communities and individuals to realize their full potential.” The MIDD aligns with the Strategic Plan and Equity and Social Justice Initiative by providing a full array of mental health, chemical dependency and therapeutic court services that help reduce or prevent involvement in the criminal justice, crisis mental health and emergency medical systems, and promote stability for individuals currently involved in those systems.

The MIDD Oversight Committee reviewed and accepted the enclosed report (Attachment A) at its meeting on February 25, 2016. A draft copy of the report was distributed to members in advance and comments from members were incorporated into the final report.

It is estimated that this report required 2,050 staff hours to produce, costing \$88,000.

The Honorable Joe McDermott

March 28, 2016

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If you have any questions, please feel free to contact Adrienne Quinn, Department of Community and Human Services Director, at 206-263-9100.

Sincerely,

Dow Constantine

King County Executive

Enclosures

cc: King County Councilmembers

ATTN: Carolyn Busch, Chief of Staff

Anne Noris, Clerk of the Council

Carrie S. Cihak, Chief of Policy Development, King County Executive Office

Dwight Dively, Director, Office of Performance, Strategy and Budget

Adrienne Quinn, Director, Department of Community and Human Services (DCHS)

Jim Vollendroff, Division Director, Behavioral Health and Recovery Division, DCHS



King County

Metropolitan King County Council Health, Housing and Human Services Committee

STAFF REPORT

Agenda Item:	9	Name:	Mary Bourguignon
Proposed No.:	2016-B0113	Date:	June 7, 2016

SUBJECT

Today's briefing will provide a summary of King County's men's downtown winter shelter operations, along with information about next steps.

SUMMARY

In response to the crisis of homelessness, King County provides funding for prevention services, emergency shelter, and permanent, affordable housing. Because people experiencing homelessness face greater risks if they are unsheltered in bad weather, the County funds a number of winter and severe weather shelters around the region. (See Attachment 1)

The County has funded a winter shelter for single men in downtown Seattle in the King County Administration Building for more than 20 years. Because that shelter has not been able to meet the need, the Council has repeatedly approved supplemental budget appropriations and sought funding partnerships with the City of Seattle to provide for additional shelter space, operating hours, or days of operations. (See Attachment 2)

For winter 2015-2016, the County's budget provided funding for 50 beds at the Administration Building from November 1, 2015, through April 15, 2016. In late 2015, the City of Seattle provided a grant to expand that shelter to 100 beds. At the same time, the Council approved an emergency appropriation from the County's General Fund to expand the shelter further by opening space for an additional 50 beds in the County-owned 420 Fourth Avenue Building, which is located across the street from the Administration Building.

That combination of funding provided downtown shelter space for 150 men through April 15, 2016. In light of the need, however, the Executive did not close the downtown winter shelter on April 15, 2016, but has continued to operate all 150 beds, despite uncertainty about funding sources and appropriation authority. In addition, the Executive extended operations at Angeline's downtown winter shelter for women through May 31, 2016.

BACKGROUND

The Scope of the Problem. On any given night, approximately 10,000 people are homeless in King County, with more than 4,500 of these people sleeping unsheltered and the remainder in emergency shelter or transitional housing.¹

All Home is the federally-designed “continuum of care” to coordinate homeless services in King County. All Home works with local jurisdictions, provider agencies, faith communities, and stakeholders to plan strategies that aim to make homelessness rare, brief and one-time. All Home helps to distribute more than \$150 million each year in federal, state, local and philanthropic funding for shelter, housing, and supportive services for people who are experiencing homelessness or are at risk of homelessness.

Last year, All Home adopted a 2015-2019 Strategic Plan² to guide the community’s efforts over the remainder of the decade. The plan notes that All Home provides funding to serve 9,400 households a year, of which just over half are experiencing homelessness for the first time. The plan also notes that King County has the third largest homeless services system in the country, with 2,870 units of emergency shelter, 1,760 units of transitional housing, 484 rapid re-housing units, and 8,337 units of permanent supportive housing.

Winter Shelters Funded by King County. Part of the region’s response to homelessness is a network of winter or severe weather shelters that are opened during the cold and wet winter months or during specific severe weather conditions. Attachment 1 provides a list of these winter shelters, along with a summary of usage and funding for the 2015-2016 winter season. As Attachment 1 shows, the network of winter shelters around the county provided 445 beds during winter 2015-2016 for a total County investment of approximately \$525,000. These winter shelters included locations in downtown Seattle, East County and South County.

Men’s Downtown Winter Shelter. The countywide list includes the men’s winter shelter in downtown Seattle (it is listed as two items on this list, one entry for the Administration Building and one for the 420 Fourth Avenue Building). King County has provided funding for this winter shelter for more than 20 years. It is currently located in the King County Administration Building and the adjacent 420 Fourth Avenue Building and operated under contract by the Salvation Army.

Funding for the men’s downtown winter shelter has been included in the County’s adopted budget each year. However, during each of the last several years, in response to increasing need, the Council has approved supplemental funding to provide for additional capacity in terms of number of beds, number of hours each night, or number of months the shelter is open. Attachment 2 provides information on the County’s

¹ Seattle King County Coalition on Homelessness, 2016 One Night Count results: http://www.homelessinfo.org/what_we_do/one_night_count/2016_results.php

² <http://allhomekc.org/the-plan/>, Approved by the King County Council via Ordinance 18097

funding history for the men's downtown winter shelter during each of the winters since fall 2012.

In late 2015, the County provided an emergency appropriation of \$239,000 for the men's downtown winter shelter,³ which was matched by a \$225,000 contribution from the City of Seattle. This additional funding was used to expand the existing shelter at the Administration Building from 50 to 100 beds and to make limited tenant improvements at the 420 Fourth Avenue Building so as to open a 50-bed shelter there. (Attachment 3 provides more information about the 420 Fourth Avenue Building's history, its purchase by the County, and its temporary use as a winter shelter.)

The additional 100 beds opened in late December 2015. Shelter in both buildings was operated by the Salvation Army under a contract with King County, with men seeking shelter forming a single line outside the Administration Building each night for entry into either building. The funding appropriated was sufficient to operate the shelter at its new 150-bed capacity from 8:30 PM-6:00 AM seven days a week through April 15, 2016.

The 420 Fourth Avenue Building also accepted dogs, and has seen a modest number of pets, with as many as three men a night arriving with a dog.

Since the additional capacity opened, the men's downtown winter shelter has been operating at or near capacity. Table 1 shows average occupancy for each month from November 1, 2015, through May 22, 2016.

Table 1. Men's Downtown Winter Shelter Average Occupancy, 2015-2016

Month	Admin Bldg (50 beds)	Admin Bldg %	Admin Lobby (50 beds)	Admin Lobby %	420 Fourth Building (50 beds)	420 Fourth Building %
November	47	95%				
December*	48	95%			28	57%
January	49	99%	17	35%	48	95%
February	50	100%	37	74%	46	93%
March	50	100%	46	92%	48	96%
April	48	97%	42	84%	45	90%
May 1-22	50	100%	43	86%	46	92%

*The additional shelter capacity opened during the last several days of December. The figures for 420 Fourth for December represent four days during the holiday season just after the building had opened as a shelter.

As the table shows, the men's downtown winter shelter did not close on April 15, 2016, as it had been budgeted to do. Instead, in light of the homelessness crisis, the Executive has chosen to keep the shelter operating indefinitely at its new 150-bed

³ Ordinance 18189 (Included appropriation authority for \$239,000, with total new funds of \$214,000, due to \$24,000 being double-budgeted)

capacity. Executive staff are currently working to develop a plan to fund these additional operations.

As an additional response to the homelessness crisis, the Executive opted to continue operations at Angeline's a 40-bed downtown winter shelter for single women, that is operated by the YWCA, through May 31, 2016. That shelter, too, had been budgeted to close on April 15, 2016. Executive staff are working to develop a plan to fund these additional operations as well. As Table 2 shows, Angeline's has been operating above capacity all winter.

Table 2. Women's Downtown Winter Shelter Average Occupancy, 2015-2016

Month	Angeline's (40 beds)	Angeline's %
November	45	113%
December	47	117%
January	48	120%
February	47	119%
March	49	124%
April	49	122%
May 1-19	48	119%

NEXT STEPS

Councilmembers may wish to address the following issues related to winter shelter funding and operations:

- 1. Funding for ongoing downtown winter shelter operations.** As noted above, the men's downtown winter shelter was funded for 150 beds through April 15, 2016. In light of the homelessness crisis, the Executive has continued to operate the shelter since April 15. A funding source will need to be identified to cover ongoing operations. (In addition, the Angeline's winter shelter for women was operated from April 15 through May 31, and Councilmembers may want to ascertain that the Executive identified funding for those additional weeks of operations.)
- 2. Funding for 2016-2017 winter shelter operations.** The 2015-2016 biennial budget⁴ provides funding for 50 beds for 9.5 hours per night for the men's downtown winter shelter, beginning on November 1, 2016. If additional capacity for fall 2016 is desired, additional funding would need to be identified in a supplemental budget appropriation. In addition, the Council will need to consider ongoing funding for this shelter and other winter shelters around the region for operations beginning on January 1, 2017, as part of its deliberations on the proposed 2017-2018 biennial budget.

⁴ Ordinance 17941

- 3. Status of 420 Fourth Avenue building.** In December 2015, the Council appropriated \$92,000⁵ for limited capital improvements to the 420 Fourth Avenue building, which received a Temporary Use Permit from the City of Seattle to be used as a winter shelter on a temporary basis. The Council may wish to consider the future of that building, which was purchased by the County to be used for office space, as well as any ongoing permit or capital improvement needs if it is to continue to be used as a shelter.

ATTACHMENTS

1. Winter Shelter Funding and Census, 2015-2016
2. Funding History for Downtown Winter Shelter, 2012-2016
3. 420 Fourth Avenue Building

INVITED

- Adrienne Quinn, Director, Department of Community and Human Services
- Mark Ellerbrook, Regional Housing and Community Development Manager, Department of Community and Human Services

⁵ Ordinance 18189

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Winter Shelters in King County: Occupancy November 2015-April 2016

Shelter	Operator	Population	Beds	Location	Dates	County Funding	Occupancy
Reach Out	Catholic Community Services (CCS)	Single men Single women	25 men 15 women	Federal Way <i>(rotating church congregations)</i>	November-March	Yes <i>Partial funding: \$100,000 for South King County Shelter System which includes Year Round Shelters for a total of 105 beds.</i>	104%
HOME Women	CCS	Single women	15	Kent	November-March	Yes <i>Partial funding: \$100,000 for South King County Shelter System which includes Year Round Shelters for a total of 105 beds.</i>	86%
Eastside Men's Shelter	Congregations for the Homeless	Single men	50	Bellevue <i>Int'l Paper site</i>	November-April	Yes <i>Partial funding: \$26,000</i>	151% <i>(Increase staffing in Fall to serve up to 80 men/night Average 76 men/night)</i>
King County Men's Winter Shelter	Salvation Army	Single men	<i>Nov-Dec 50 Jan-Apr 100</i>	Seattle <i>Admin Building</i>	November- April	Yes: \$97,673	88%
King County Men's Winter Shelter	Salvation Army	Single men	50	Seattle <i>420 4th Ave.</i>	Opened 12/28 – 4/30	Yes: \$109,987	93%
Snoqualmie Valley Winter Shelter	Congregations for the Homeless	Men, women, families	15	Snoqualmie <i>United Methodist</i>	Dec. - April	Yes <i>Partial funding: \$25,000</i>	50%
Eastside Women & Family Winter Shelter	CCS / Sophia Way	Single women and families –	45	Eastside <i>(rotating church congregations)</i>	Nov-Jan. 16 th	Yes <i>Partial funding: \$50,000</i>	94%
Eastside Single Women (new 2016)	CCS / Sophia Way	Single Women	45	Eastside	Jan. 17 th - April	Yes <i>Partial funding \$50,000</i>	44%
Eastside Women and Children	CCS	Families	45	Eastside	Jan. 17 th - April	Yes <i>Same funding as combined families and singles</i>	60%
King County Women's Winter Shelter	YWCA –Angeline's	Single women	40	Seattle <i>Third & Lenora</i>	Oct-March	Yes: \$65,351	119%

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KING COUNTY DOWNTOWN MEN'S WINTER SHELTER**Winter 2012-2013**

	As Budgeted¹	Actually Implemented²
Hours Open per Night	8 hours	9.5 hours
Days Open per Year	5.5 months (Nov 1-Apr 15)	8.5 months (Nov 1-Jun 15)
Number of Beds	50 beds	100 beds

¹Ordinance 17232 for 2012, Ordinance 17476 for 2013

²Ordinance 17619 provided supplemental appropriation authority to increase the number of beds, hours, and days

Winter 2013-2014

	As Budgeted³	Actually Implemented⁴
Hours Open per Night	9.5 hours	9.5 hours (Nov-April 15) 11 hours (April 16-June 30)
Days Open per Year	5.5 months (Nov 1-Apr 15)	9 months (Nov 1-Jun 30)
Number of Beds	50 beds	50 beds

³Ordinance 17476 provided baseline funding for 2013 and 2014 (biennial budget).

Ordinance 17619 provided supplemental funding for 2013

⁴Ordinance 17855 provided supplemental appropriation authority to increase the number of hours and days in 2014

Winter 2014-2015

	As Budgeted^{5, 6}	Actually Implemented⁷
Hours Open per Night	11 hours (Oct-Dec) 9.5 hrs (8:30P-6:00A, Jan-Apr 15)	11 hours (7:00-6:00)
Days Open per Year	6 months (Oct 1-Apr 15)	6 months (Oct 1-April 15)
Number of Beds	50 beds	50 beds (Oct-Dec) 100 beds (Jan-Apr 15)

⁵Ordinance 17855 provided supplemental funds to open on October 1 and to operate 11 hours a night through 2014.

⁶Funding for the winter shelter for January 1, 2015, through December 31, 2016, was included in Ordinance 17941, the 2015-2016 biennial budget ordinance: 5.5 months (November 1 – April 15) and 9.5 hours per night.

⁷Ordinance 17966 (January 2015) provided emergency appropriation authority of \$170,000 (\$117,000 from the City of Seattle and \$59,000 from the General Fund) to increase shelter hours to 11 and increase shelter beds by 50.

Winter 2015-2016

	As Budgeted⁸	Actually Implemented⁹
Hours Open per Night	9.5 hrs (8:30P-6:00A)	9.5 hrs (8:30P-6:00A)
Days Open per Year	5.5 months (Nov 1-Apr 15)	Uncertain (Nov 1 - ???)
Number of Beds	50 beds	50 beds (Nov1-Dec 28) 150 beds (Dec 28-???)

⁸Ordinance 17941 (biennial budget ordinance) provided funding for 50 beds for 5.5 months (November 1 – April 15) and 9.5 hours per night.

⁹Ordinance 18189 (December 2015) provided emergency appropriation authority of \$239,000 to make limited capital improvements to 420 Fourth Avenue to operate it as a temporary winter shelter with 50 beds. The City of Seattle provided a grant of \$225,000 to increase the capacity of the Admin Building shelter to 100 beds, for a total of 150 beds. Funding and appropriation authority were to expire on April 15, 2016, but the 150 beds remain open as of late May and there is no closure date set. The Executive will need to identify additional funds to support operations from April 15, 2016, onward.

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420 Fourth Avenue Building

History. The 420 Fourth Avenue Building (also known as the Zombie Building due to its former tenant, Zombie Studios) was built in 1924. It is a 10,000 square foot, two-story standalone brick building, situated on a 4,260 square foot lot. Each floor of the building is approximately 4,000 square feet. The building also contains a 2,000 square foot mezzanine. Originally, the ground floor of the building was used as retail space, with residences located on the second floor. Over the years, tenants of the building have included restaurants, a bookbinder, jewelry manufacturer, beauty shop, and a lighting fixture retail store.

The property is located on the corner of Jefferson Street and Fourth Avenue, directly south of the King County Administration Building and east of the King County Courthouse. The property is located on the same block as the Chinook building.

The 420 Fourth Avenue Building was renovated by the previous owner—Itchy 'N Scratchy, LLC—in 2004. Following that renovation, the owner used the building as commercial office space, operating Zombie Studios, a video game development company. The property was placed on the market for sale at the end of 2014 due to the retirement of the two members of Itchy 'N Scratchy, LLC. The property was marketed commercially, at a list price of \$2.5 million.

Purchase. The 420 Fourth Avenue Building was purchased by King County in 2015. The Council approved an appropriation of \$2.68 million to fund the purchase price, closing costs, and one year of operations and maintenance.¹

During Council briefings regarding the proposed appropriation to purchase the building, Executive staff indicated their expectation that the building would be used for office space, particularly since the County had a fairly immediate need to relocate the agencies and departments currently located in the County-owned Yesler Building, which is slated for redevelopment.

However, at that time, Executive staff had not yet determined which County agencies or departments might be located in the 420 Fourth Avenue Building. As a result, the Council declined to fund any tenant improvements for the building, removing from the proposal a total of \$871,817 that had been proposed for interior repairs and improvements that would be needed prior to occupancy.² (Note that the building also needs some level of exterior repairs, but these have not yet been identified or scoped.)

¹ Ordinance 18058

² These improvements (which were proposed by the Executive but not funded by the Council) included installing a fire alarm system, relocating the gas meter to the building's exterior, addressing electrical service issues, installing building security, and installing communications systems in the building.

Use as a Winter Shelter. Shortly after approving the appropriation for the purchase of the 420 Fourth Avenue Building, the Council considered a report transmitted by the Executive on possible options to expand downtown winter shelter. This report had been required as part of a proviso in the biennial budget ordinance.³

The report identified several privately-owned buildings in the SODO neighborhood that could potentially be used for winter shelter, but recommended against them due to the high cost of required life-safety tenant improvements and the need to fund year-round rental of the buildings. The report also analyzed the potential for use of the 420 Fourth Avenue Building as a winter shelter, but recommended against it due to the uncertainty of its situation (the County was considering whether to purchase the building at the time the report was prepared, but had not finalized a purchase and sale offer) and also because of the high estimated cost of needed tenant improvements (as noted above, the Executive's initial estimate of needed tenant improvements prior to occupancy was nearly \$1 million).

During the course of the Council's deliberations on the winter shelter report, Executive staff were able to secure an agreement with the City of Seattle that the 420 Fourth Avenue building could potentially be operated temporarily as a winter shelter using a Temporary Use Permit. Use of a Temporary Use Permit would waive most of the required tenant improvements but would allow only short-term use.

Following the Council's review of the winter shelter report, the Council drafted and adopted Motion 14457, which expressed support for an expansion of the King County Homeless Winter Shelter for winter 2015-2016 and asked the City of Seattle to partner with the County in providing expanded shelter. The motion specifically asked the Executive to increase the number of downtown winter shelter beds from 50 to 150 and asked that these be located "either at the currently location of the King County Administration Building or at another King County-owned facility in downtown Seattle, or at both."

In response to Motion 14457, the Executive proposed an emergency appropriation of \$239,000⁴ to open a 50-bed shelter at the 420 Fourth Avenue Building for the remainder of winter 2015-2016. The emergency appropriation included \$92,000 in tenant improvements to the 420 Fourth Building⁵ as the minimum needed to satisfy a Temporary Use Permit with the City of Seattle; as well as funds to operate the building as a shelter. The Council approved this emergency appropriation in December 2015⁶ and a winter shelter was opened in the 420 Fourth Avenue Building several weeks later.

³ Motion 14440 acknowledged receipt of this report.

⁴ \$239,000 in emergency appropriation authority but a total in new funds of \$214,000 due to \$24,000 being double budgeted.

⁵ Double doors for the building entrances, emergency lighting, exit signage, enhanced security gates, and updated smoke and carbon monoxide detectors were identified by the City of Seattle as required for a Temporary Use Permit

⁶ Ordinance 18189

Following the emergency appropriation for the 420 Fourth Avenue Building, the City of Seattle offered to fund an additional 50 beds at the Admin Building winter shelter for the remainder of winter 2015-2016, allowing the County to open additional capacity in the lobby of that building by the end of December.

Current Status of 420 Fourth Avenue Building. The County secured a Temporary Use Permit from the City of Seattle to use the 420 Fourth Avenue Building as a temporary winter shelter through April 15, 2016. In addition, as noted above, the Council approved an emergency appropriation from the General Fund sufficient to operate a 50-bed shelter in the building through April 15, 2016. Given the homelessness crisis, the Executive continued operating the building as a shelter beyond April 15.

There have not yet been any decisions made about long-term use of this building for shelter. Policy issues the Council would face in extending the building's use as a shelter would include:

- Where to house County agencies and departments that may need this space if the 420 Fourth Avenue Building is not available for office space use;
- Whether the City of Seattle would be willing to renew or extend the Temporary Use Permit for the 420 Fourth Avenue Building for continued use as a shelter or whether it would require a full use permit and a more extensive list of tenant improvements; and
- How the County would fund ongoing shelter operations since the use of the 420 Fourth Avenue Building as a shelter from December 2015 through April 2016 was funded through an emergency appropriation and is not in the County's base budget.

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King County

Metropolitan King County Council Health, Housing and Human Services Committee

STAFF REPORT

Agenda Item:	10	Name:	Lauren Mathisen
Proposed No.:	2016-B0112	Date:	June 7, 2016

SUBJECT

A briefing on the implementation status of the All Home Strategic Plan one year after adoption.

SUMMARY

All Home is a coalition of local governments, non-profit organizations, faith communities, people experiencing homelessness, and businesses that have been working together to make homelessness rare, brief and one-time. All Home is the federally-recognized “continuum of care” for King County, with formal responsibility for homelessness planning and administering federal homeless services funds.

Several years ago, All Home began working with diverse community stakeholders including providers, funders, and people experiencing homelessness to develop a Strategic Plan for 2015-2019 to direct regional efforts toward making homelessness rare, brief, and one-time. The Strategic Plan, which was adopted in 2015,¹ has three goals: (1) Make homelessness rare; (2) Make homelessness brief and one-time; and (3) Develop a Community to End Homelessness. The Strategic Plan also aims to eliminate racial disparities, as people of color are disproportionately likely to experience homelessness.

During each year covered by the Strategic Plan, All Home will assess its progress and create an updated implementation plan including targets for each strategy. As the first year of the plan concludes (plan years are July-June), All Home is working on its first annual implementation plan and report on its progress, which will be released in summer 2016. This briefing will provide background on All Home’s Strategic Plan, an overview of major initiatives, and a report on the success of first year efforts.

¹ Ordinance 18097

BACKGROUND

Formed in 2005, All Home is a coalition of local governments, non-profit organizations, faith communities, homeless people, and businesses that have been working together to prevent and end homelessness. As the federally-recognized “continuum of care” for King County, All Home has formal responsibility for homelessness planning and administering federal homeless services funds.

Strategic Plan. In 2015, after a lengthy stakeholder process including funders, providers, and people experiencing homelessness, All Home adopted a 2015-2019 Strategic Plan (Attachment 1) to direct continuing efforts toward making homelessness rare, brief and one-time. The plan was adopted by Council via Ordinance 18097 in August 2015 and was also ratified by the All Home Coordinating Board,² the Cities of Seattle and Bellevue, and the Sound Cities Association.

The plan set out three overarching goals and identified specific, actionable strategies to achieve them. The Strategic Plan also aims to eliminate racial disparities, as people of color are disproportionately likely to experience homelessness. The plan will guide the efforts of All Home from 2015 through 2019. Reflected in the plan are a commitment to a data-driven culture as well as All Home’s efforts to meet federal goals, which call for ending veteran homelessness by the end of 2015, ending chronic homelessness by 2017, ending family and youth/young adult homelessness by 2020, and ending single adult homelessness.³

The goals and strategies stated in the Strategic Plan are:

1. **Make homelessness rare.** All Home aims to address the causes of homelessness through action at all levels of government.
 - 1.1 **Advocate and align systems to prevent people from experiencing homelessness.** Invest prevention resources in communities where the need and opportunity are greatest; collaborate with other mainstream systems, including education, juvenile justice, foster care, and mental health; and assure availability of critical services frequently needed by people with chronic disabilities and other vulnerable populations.
 - 1.2 **Advocate and support partners to preserve existing and create more affordable housing for those making below 30 percent of area median income.** Increase access for people at risk of homelessness to existing housing; and advocate for federal, state, and local housing funding.
 - 1.3 **Expand evidence-based pre-adjudication and post-conviction sentencing alternatives that minimize involvement in the criminal justice system for people experiencing homelessness.** Programs include

² The Committee to End Homelessness Interagency Council and Governing Committee were consolidated into the All Home Coordinating Board.

³ All Home 2015-2019 Strategic Plan, p. 3.

diversion courts and LEAD (Law Enforcement Assisted Diversion), and post-conviction sentencing alternatives.

2. **Make homelessness brief and one-time.** Ensure that people who experience homelessness quickly receive the right services and that more people are served with existing programs.
 - 2.1 **Address crisis as quickly as possible.** Ensure that there is enough shelter space for all who need it, increase support for crisis response needs, and expand capacity to divert people from shelter.
 - 2.2 **Foster collaboration between first responders, service providers, and local communities to increase housing stability for those experiencing homelessness.** Develop and support partnerships between behavioral health and social service providers, neighborhood associations, and local government; and assess local policies, practices, and ordinances that disproportionately affect those experiencing homelessness.
 - 2.3 **Assess, divert, prioritize, and match people with housing and supports.** Ensure there is a coordinated assessment system to match people with housing, link people with employment services, ensure housing programs reflect Housing First practices, and improve access to civil legal aid.
 - 2.4 **Right-size housing and supports to meet the needs of people experiencing homelessness.** Base homeless housing on typology and needs, increase rapid re-housing opportunities, increase permanent supportive housing for those who are chronically homeless, convert transitional housing to permanent housing, use Housing First practices, and ensure culturally appropriate and geographically diverse services.
 - 2.5 **Increase access to permanent housing.** Expand and coordinate landlord outreach and engagement; expand permanent housing options, such as shared housing, host homes, and SROs; increase subsidized low income housing available to those experiencing homelessness.
 - 2.6 **Create employment and education opportunities to support stability.** Recruit businesses to train and hire people who have experienced homelessness; increase access to employment programs; increase access to services to gain and sustain employment and manage finances; link with other services, such as education programs; and improve data collection and the employment and education needs of those experiencing homelessness.
3. **Develop a Community to End Homelessness.** Solving homelessness will require engagement of and commitment by a diverse set of community members and groups, not just a committee.
 - 3.1 **Engage residents, housed and homeless, to take community action.** Launch a community-wide public awareness and engagement campaign,

create a business leaders task force, and expand efforts to engage faith communities.

3.2 Provide effective and accountable community leadership. Reformulate CEH governance, and engage local governments, philanthropic organizations, and community partners.

During each year covered by the Strategic Plan (2015-2019), All Home is to assess its progress and create an updated implementation plan including targets for each strategy. As the first year of the plan concludes (plan years are July-June), All Home is working on its first annual implementation plan and report on its progress, which will be released later this summer.

Major Initiatives.

Coordinated Entry for All. All Home is leading the implementation of Coordinated Entry for All (CEA). Coordinated entry systems are a requirement of the 2009 Federal Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act and provide a single point of entry to affordable housing programs.⁴

CEA will be integrated into the region's Homeless Management Information System (HMIS).⁵

The implementation of CEA in King County incorporates Housing First principles by lowering barriers to entry for housing programs and by expanding diversion and flexible funding to all households seeking shelter, preventing unnecessary entry into shelter and freeing up shelter capacity.

Status of Key CEA Efforts:

- The Department of Community and Human Services (DCHS) is in the process of contracting with community-based providers for geographically diverse Regional Access Points (RAP), where people experiencing or at risk of homelessness can go to receive an assessment⁶
- DCHS has hired a Coordinated Entry for All Program Manager
- King County will assume operations for existing Family and Young Adult Coordinated Entry on June 27th

⁴ Coordinated entry systems are intended to ensure that people experiencing a housing crisis have the opportunity to be quickly and equitably assessed, then connected to housing based on their needs. All Home's vision for coordinated entry would unite existing coordinated entry systems for youth and families and integrate them into the Homeless Management Information System (HMIS), a database that contains information on people experiencing homelessness and the services they access.

⁵ A Homeless Management Information System (HMIS) is a database used to collect and analyze information about people who are experiencing homelessness. In early 2016, the HMIS transitioned to a new database vendor and was transferred to King County from the City of Seattle's Human Services Department. This transfer co-located the HMIS with All Home (also hosted at King County) as it leads the implementation of CEA. The HMIS is already being used for tracking assessments and referrals for family and young adult coordinated entry.

⁶ There will be two located in South King County, one in Seattle, and one in North King County. Due to a lack of responses, a second request for proposals has been issued for a RAP location in East King County.

- CEA will launch in July 2016

Data-Driven Strategies

The All Home Strategic Plan calls for robust efforts to measure progress and adapt practices based on data. As part of the Strategic Plan action steps, All Home and stakeholder organizations committed to using the System-Wide Analytics and Projection (SWAP) suite of tools to support ongoing systems planning and change efforts.

King County, the City of Seattle, and United Way of King County jointly funded consultant Focus Strategies to provide a SWAP system analysis, which will assist All Home to use local data to realign funding and programming and improve investment alignment with King County funders. Focus Strategies will release a final report in late summer with SWAP findings and resulting recommendations.

ATTACHMENTS

1. 2015-2019 All Home Strategic Plan

INVITED

1. Mark Putnam, Executive Director, All Home

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STRATEGIC PLAN

acknowledgements

Governing Board

Dan Brettler	<i>Car Toys Inc. (Co-Chair)</i>
Ed Murray	<i>Mayor, City of Seattle (Co-Chair)</i>
Lydia Assefa-Dawson	<i>Councilmember, City of Federal Way</i>
Dahkota Beckham	<i>Consumer Advocate</i>
David Bley	<i>Bill & Melinda Gates Foundation</i>
Bobbe Bridge	<i>Former Judge, Center for Children & Youth Justice</i>
John Chelminiak	<i>Councilmember, City of Bellevue</i>
Sally Clark	<i>Councilmember, City of Seattle</i>
Jon Fine	<i>United Way of King County</i>
Paul Killpatrick	<i>Seattle Central College</i>
Doreen Marchione	<i>Councilmember, City of Kirkland</i>
Kathy Lambert	<i>Councilmember, King County</i>
Mike Lowry	<i>Former Washington State Governor</i>
Nicole Macri	<i>DESC, Seattle-King County Coalition on Homelessness</i>
Joseph McDermott	<i>Councilmember, King County</i>
Blake Nordstrom	<i>Nordstrom, Inc.</i>
Sheila Sebron	<i>Consumer Advocate</i>
Lainey Sickinger	<i>Renton Ecumenical Association of Churches</i>
J. Wesley Saint Clair	<i>Judge, King County Superior Court</i>
Father Stephen Sundborg	<i>Seattle University</i>

Consumer Advisory Council

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Daniel	Ed Murray	<i>Governing Board</i>
Dahkota	Sue Sherbrooke	<i>Interagency Council</i>
Eddy	Adrienne Quinn	<i>Interagency Council</i>
Latrice	Meghan Altimore	<i>Safe Harbors, Hopelink</i>
Linda	Sara Levin	<i>Safe Harbors, Communications (for Chris Hynes)</i>
Margaret		
Nancy	Marty Kooistra	<i>Communications</i>
Roger	Stacy	<i>Consumer Advisory</i>
Stacy	Bill Hallerman	<i>Data/Evaluation</i>
	Catherine Lester	<i>Data/Evaluation (for Traci Hilliard)</i>
	Open seat	<i>Sound Cities Association</i>

Interagency Council

Adrienne Quinn	<i>King County/Community and Human Services (Co-Chair)</i>
Sue Sherbrooke	<i>YWCA (Co-Chair)</i>
Jarvis Capucion	<i>Occupy CEH</i>
Roger Conn	<i>Consumer Advisory Council</i>
TJ Cosgrove	<i>Public Health Seattle & King County</i>
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Thanks!

Contributions to this plan were made by more than 500 people, including All Home subcommittee members, Sound Cities Association, City of Seattle and King County staff, 2014 Annual Conference participants, 2015 Strategic Planning Session attendees, and those who commented via our website.

Photo credits: Front cover, family portrait courtesy of Dan Lamont and Seattle University's Project on Family Homelessness.

A special thank you is owed to [Point B](#) for their pro bono contributions.

All Home

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introduction

In 2005, our community formed All Home -formerly the Committee to End Homelessness in King County (CEH), creating a broad coalition of stakeholders to focus on addressing and eliminating homelessness in King County. Since the adoption of a [10-Year Plan to End Homelessness](#) (2005-2015) our community has succeeded in ending homelessness for almost 40,000 people.

Yet, in 2015, on a given day, nearly 10,000 people are experiencing homelessness in King County, and almost 40 percent are unsheltered. People are homeless on average for more than 100 days, and they return to homelessness after being housed nearly 20 percent of the time. Racial disparities are stark, with Native Americans seven times more likely to experience homelessness than Whites, and African Americans five times more likely.

Homelessness is a crisis in King County. Our neighbors who are without homes need housing. Many also need jobs. We are a compassionate, active community that hurts for those living outside and in unstable housing. While we can celebrate with those who have found housing stability over the past decade, we are recommitting to develop new partnerships and make a greater impact over the next four years.

All Home has taken a collective impact approach to ending homelessness in King County that aligns strategy and funding toward shared outcomes. Our ranks include residents, housed and unhoused, alongside the faith, business, government, philanthropic, and nonprofit sectors. We realized a long time ago that we need to work collectively, across sectors and across the entire County and region, to end homelessness.

To make homelessness brief and one-time, we need to provide people with what they need to gain housing stability quickly. This is the responsibility of funders of homeless housing and services, and nonprofit providers. Implementing more effective, efficient program models will allow us to serve more people.

Homelessness is solvable. While crises that impact housing stability will never be fully prevented, we can end that person's homelessness very quickly. Other cities and states are making significant progress, and we must continue to learn and adapt to new data and ideas.

To make greater strides locally, we must address the symptoms while also working with others at the local, state, and federal levels to address the causes. We must commit fully to using the most effective, proven approaches to support people experiencing homelessness to quickly gain housing stability and employment, prioritizing those who are most vulnerable. **We will need the support and commitment of local, state, and federal elected officials to ensure housing affordability and the availability of safety net services.** We save money and have a stronger community when people have a place to call home.

Finally, we must energize and activate residents, business, and the faith community. **This plan outlines strategies for a re-imagined continuum of services for people experiencing homelessness in King County and acknowledges that energized engagement needs to take place in both the board room and between neighbors for homelessness to be rare, brief, and one-time in our community.**

our vision and new plan

Our vision is that homelessness is rare in King County, racial disparities are eliminated, and if one becomes homeless, it is brief and only a one-time occurrence.

On July 1, 2015, All Home will launch a new four-year Community Strategic Plan, A Regional, Aligned, Community Plan to End the Experience of Homelessness among Residents of Seattle/King County to achieve this vision. The plan is a recommitment to our vision of ending homelessness, and to the steps needed to make this vision a reality.

What are Our Goals, Strategies and Outcomes?

The plan has three core goals, strategies to address them, and outcomes to measure progress:

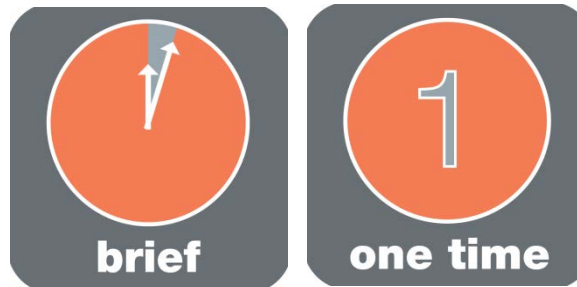
Make Homelessness Rare



Advocacy and action to address the true causes of homelessness, **resulting in:**

- ➔ Fewer people unsheltered or temporarily housed
- ➔ More people housed and sheltered
- ➔ Reduced racial disparities among people experiencing homelessness
- ➔ Fewer people exiting institutions directly into homelessness
- ➔ Fewer low-income households spending >50% income for housing

Make Homelessness Brief and One-Time



Address crisis quickly, and align resources to meet the needs and strengths of people, **resulting in:**

- ➔ People experiencing fewer days homeless
- ➔ Fewer people losing housing stability once housed
- ➔ Increased income
- ➔ Reduced racial disparities among people experiencing homelessness

A Community to End Homelessness



Engage and activate the community, **resulting in:**

- ➔ Increased engagement of residents
- ➔ Increased leadership of business and faith leaders
- ➔ Effective and efficient governance and system infrastructure

(See Appendix A for additional information on local Performance Measures and Dashboards.)

How Much Progress Will Be Made?

Since 2005, we have become more sophisticated in our ability to measure progress and adapt practices based on data. As a community we have already set a goal of ten percent annual improvement for each outcome, and local funder contracts with providers include annual program targets that if met will help us achieve our system targets. We will refine these goals by year-end 2015 as we set implementation plans by population and utilize a new National Alliance to End Homelessness ([NAEH](#)) [System Wide Analytics and Projection](#) (SWAP) suite of tools that

model program and population changes to assist communities to project improvements to system outcomes.¹ The tools, utilizing local data, will provide us with information we can use to realign our funding and programming. The tools will be used to identify resource gaps, by program type and population, and set implementation plans to achieve our goals. (See Appendix B for more on Predictive Modeling.)

In advance of the release of these tools, All Home and [Point B](#) (providing pro bono services) used local data and national research to project the impact of realigning programming. We found that by increasing and targeting our investments to focus on diversion, rapid re-housing, and permanent supportive housing we will house more people—often with equal or better housing retention outcomes than our current system.

In addition, our goals are aligned with the U.S. Interagency Council on Homelessness [Opening Doors](#) plan², which set out the following objectives:

- End Veteran Homelessness by 2015: Our goal is for all Veterans to be housed or in shelter and on a pathway to housing (what USICH is calling “functionally zero” homeless). We believe we can achieve this goal, as we have permanent housing resources for about 900 of the 1096 Veterans who are homeless in King County.
- End Chronic Homelessness by 2017: Our goal is for all chronically homeless adults to be housed or in shelter and on a pathway to housing.³ This will require significant new investment in Permanent Supportive Housing, the evidence-based solution to chronic homelessness.
- End Youth/Young Adult Homelessness by 2020: Our goal is for all youth/young adults to be housed or in shelter and on a pathway to housing, and to rapidly house those who become newly homeless.
- End Family Homelessness by 2020: Our goal is for all homeless families to be housed or in shelter and on a pathway to housing, and to rapidly house those who become newly homeless.
- USICH and Opening Doors have not set a goal for ending Single Adult Homelessness. King County will set a target this year as part of our first ever single adult plan.

When Do We Begin? Now!

We’ve set ambitious 2015-2016 action steps, which are specified in this plan. Annual implementation plans will be developed, including setting targets for each strategy, and future meetings of our governance committee will be organized around these strategies. Lead partners will be accountable for updating the committee on progress, and the committee will provide oversight and make course corrections.

Implementation plans by subpopulation will be developed and continuously refined as new data emerges. These plans will be amendments to the Strategic Plan following adoption by the All Home governance committee:

- Veterans (existing plan runs through 2015; update in Quarter 1 2016)
- Youth/young adults (update completed June 2015)
- Families (existing plan runs through 2015; update to be completed in Quarter 1 2016)
- Single adults and chronically homeless (no current plan; plan completed by Quarter 4 2015)

¹ [Focus Strategies](#), under contract with NAEH, developed a suite of tools they call System Wide Analytics and Projection (SWAP). These tools will assist our community in using our local data to realign our funding and programming and project what policy changes will make the most impact.

² USICH released Opening Doors in 2010, and amended it in 2013. A second amendment was released in June 2015 and includes a new target for ending chronic homelessness in 2017 (from the previous target of 2015), due to lack of investment by the Federal Government in Permanent Supportive Housing (PSH).

³ HUD has defined **chronic homelessness** as an individual or family with a disabling condition who has been continuously **homeless** for a year or more or has had at least four episodes of homelessness in the past three years. <https://www.hudexchange.info/homelessness-assistance/resources-for-chronic-homelessness/>

What Principles Will Guide Us?

Our goals, strategies and outcomes provide us with a framework. Principles provide us with a foundation for our collective action over the coming four years. The following principles will guide us:

- Involve the full community, including those experiencing homelessness
- Promote equity and social justice in funding and program design to address regional and racial disparities
- Address a person's unique needs and strengths by prioritizing appropriate housing stability mechanisms
- Prioritize those whose health and safety are most vulnerable
- Move people into housing first, and employment fast, by progressive engagement in services
- Utilize data-driven assessment of needs and outcomes to drive policy and investments

How Did We Get Here? Community Engagement!

During the summer of 2014, we began the process of establishing a new vision and plan for making homelessness rare, brief and one-time in King County. The full community is needed to make this plan a success, and hundreds of King County residents engaged in the planning that resulted in this plan.



More than 500 individuals participated in planning, providing expertise, ideas, critical review, leadership, and vision over the course of nearly one year. Participation has included:

- All Home Governing Board, Consumer Advisory Council, Interagency Council (IAC), and IAC subcommittees and workgroups
- 2014 All Home Annual Meeting
- All Home Strategic Plan community feedback sessions and online public comment
- Local government council and committee hearings
- Regional homeless housing meetings/forums

The planning culminated in a strategic planning session in March 2015 among All Home Governing Board, Consumer Advisory Council, Interagency Council (IAC) members, and other community leaders.



Why Plan? It's Smart, and Required.

This plan is a community-wide strategic plan for addressing the crisis of homelessness in King County, Washington. All Home, and its inclusive, growing membership, will provide leadership for the implementation of the plan. The implementation of strategies must be tailored to the varied needs of people, including veterans, youth, families, single adults, and chronically homeless.

This plan fulfills Federal and State requirements that local jurisdictions receiving funding must have a community plan for addressing homelessness. All Home is the U.S Department of Housing and Urban Development (HUD) designated Continuum of Care for the Seattle/King County area, with the City of Seattle and King County providing fiduciary oversight.⁴ King County is the designated recipient of State Consolidated Homeless Grant funding from the Washington State Department of Commerce.⁵

The plan, and its implementation action plans, will guide the distribution of Federal and State funding sources that are specifically designated for addressing homelessness, including:

- U.S. Department of Housing and Urban Development Continuum of Care Program, as amended by the Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act
- Washington State Department of Commerce Consolidated Homeless Grant Program

Alignment of other funding sources will be sought to maximize the collective impact of the funding that is designated for addressing homelessness, including:

- Local government funding designated for addressing homelessness, including levies, general funds, and other locally guided sources and plans, including the Consolidated Plan
- Philanthropic and other private sector funding
- Faith based assets, including volunteers, physical units and funding
- Federal sources from participating U.S. Interagency Council on Homelessness departments, especially HUD, Health and Human Services, Veterans Affairs, and Labor
- Related systems funding, including behavioral and physical health, criminal justice, affordable housing, veterans, workforce development, and education

This plan also seeks to align with other system plans underway or being developed, including the City of Seattle's [Homeless Investment Analysis](#) and [Housing Affordability and Livability Agenda](#), King County's [Health and Human Services Transformation Plan](#) and [Youth Action Plan](#), and other related local and regional planning efforts.

⁴ HUD requires that each Continuum of Care develop a plan that coordinates implementation of a housing and service system, conducts a Point-in-Time count of homeless persons, analyzes needs and provides strategies to address gaps in housing and services, provides information required to complete the Consolidated Plan(s), and plans for and evaluates performance of Emergency Solutions Grant (ESG) recipients <https://www.hudexchange.info/coc/coc-program-law-regulations-and-notice/>

⁵ Commerce required plans to run through 2015: <http://www.commerce.wa.gov/Programs/housing/Homeless/Pages/default.aspx>

Whose Plan is this? Yours!

Funding is just a part of what makes a plan go. Leadership and on the ground action are needed to implement this plan. This plan was created by the community, for the community.

All Home itself has minimal authority to make change. For example, All Home does not control the resources of the City of Seattle, the City of North Bend, the Gates Foundation, or King County. It does not operate the shelters or provide job training. The success of All Home and this plan is dependent on the development of an engaged community, and building a belief that we are better off working together than in isolation.

To achieve our goals it will take all of us playing our roles:

- ➔ **Local Government:** 39 cities and King County government have shown a commitment to working toward collaborative solutions through All Home, the [Sound Cities Association](#) and other regional cooperation. This plan provides a roadmap for regional collaboration, provides each local government with opportunities for action, and outlines challenges to be addressed with local providers and residents. All Home will continue to partner with local government and provide support in local/regional initiatives.
- ➔ **Faith Community:** individual congregations and associations or initiatives such as [Church Council of Greater Seattle](#), [Interfaith Task Force on Homelessness](#), Seattle University's [Faith and Family Homelessness Initiative](#), and Renton Area Ecumenical Association of Churches ([REACH](#)) are demonstrating the impact the faith community can have through education, advocacy, grassroots organizing, and service delivery. This plan will not be successful without their efforts, and we must support them to grow their impact.
- ➔ **Philanthropy:** our local philanthropic community, including [United Way of King County](#), [Bill & Melinda Gates Foundation](#), [Building Changes](#), and [Raikes Foundation](#), among many others, has provided catalytic funding, infrastructure supports, awareness raising, leadership, and vision. This plan provides opportunity for their role to include community leadership in addition to investment.
- ➔ **Nonprofits:** large and small nonprofits provide direct services to people who are suffering from the experience of homelessness and include associations, such as [Seattle/King County Coalition on Homelessness](#), [Housing Development Consortium](#), and the [Washington Low Income Housing Alliance](#). This plan is reflective of their vision and experience, and provides opportunities for expanding programs and continuous learning.
- ➔ **Businesses:** led by Dan Brettler of Car Toys and Blake Nordstrom of Nordstrom, the business community has been a stalwart contributor to our efforts to end homelessness. This plan provides further opportunity for impact through the Business Leaders Task Force, units from landlords, and jobs from employers.
- ➔ **Residents**, including those housed and unhoused: people experiencing homelessness have been integral to our community's response to homelessness, through efforts such as All Home's [Consumer Advisory Council](#), [Youth Advocates Ending Homelessness](#), and [Occupy CEH](#). Residents are engaging in many ways, including in traditional ways such as volunteering and donating, and new ways such as the [Hack to End Homelessness](#), and [Homeless in Seattle](#). This plan envisions connecting our community more deeply together.
- ➔ **Health Care Systems:** Hospitals, community health centers, behavioral health centers, and public health centers are critical entry points for homeless individuals and families disconnected from any homeless system supports. Addressing urgent and chronic health care needs often provides a conduit to other essential support services reducing barriers/increasing opportunities for housing. Discharge coordination between health and other systems is critical to reducing recidivism.
- ➔ **All Home** itself will need to adapt to lead the implementation of this plan, including shifting governance and adapting staffing roles to support new strategies and direction. The plan sets a new structure for All Home, combining the Governing Board and Interagency Council into a single "Coordinating Board". Additionally, because the strategies outlined in this plan cannot succeed in isolation, All Home will also recognize and support local community efforts to end homelessness.

a decade of growing inequality: 2005-2015

In 2005, our community formed All Home -formerly the Committee to End Homelessness, and adopted a [10-Year Plan to End Homelessness](#) (2005-2015). These plans were promoted by the Federal Government and eventually required by Washington State. King County's plan focused on preventing homelessness, coordinating countywide, building political will, securing 9,500 units of housing, providing culturally competent services, and measuring progress.

The plan set an aspirational goal for the community. Then, as now, our community would not and will not accept that people are living outside unsheltered in a place of such beauty and prosperity. Over the past decade, the community responded with unprecedented partnerships and results. Nearly 40,000 people exited homelessness for stable housing, and 85 percent stabilized in that housing for at least two years. More than 5,700 units of housing were secured, and Seattle/King County now has the third most housing for the homeless in the nation. Innovative public/private partnerships were developed, including the [Campaign to End Chronic Homelessness](#), [Landlord Liaison Project](#), [Family Homelessness Initiative](#), and the [Homeless Youth and Young Adult Initiative](#). Funding has increased through state and local levies, businesses, faith communities, nonprofits, local governments, and people experiencing homelessness came together like never before to address the crisis of homelessness.

Though the Seattle/King County region boomed economically from 2005-2008, it then lost significant ground during the Great Recession. As of 2014, the region had [replaced all the jobs](#) lost in the recession and Seattle led the nation in [population growth](#) per capita. Yet, at the same time across the county, poverty increased, rising 80 percent in suburban areas, with most of that growth in South County.⁶ Between 2000 and 2011, [only five percent](#) of the 85,000 new King County households earned between \$35,000 and \$125,000. [Disparities](#) are stark, as 27 percent of Black households are living in poverty, compared to eight percent of White households.

Despite progress in [increasing wages](#), erosion in renter incomes coupled with a surge in demand for rental housing has pushed the number of households paying excessive shares of income for housing to record levels,⁷ and home sales and rental prices are on the rise. In Washington State, incomes for the lowest earning residents have not grown, but the poorest Washington residents pay more in taxes than the poor do anywhere else in the country⁸. As Seattle Mayor Ed Murray, co-chair of All Home's Governing Board, warned, "[Income inequality is real](#), and it's growing in Seattle."⁹

At the Federal Level, the recession, and later, [sequestration](#), significantly reduced funding for affordable housing and homeless programs during the past decade. In 2010, the U.S. Interagency Council on Homelessness developed a ten-year Federal plan called [Opening Doors](#), calls for ending Veteran homelessness by 2015, chronic homelessness by 2017, Youth/Young Adult and Family homelessness by 2020.¹⁰ The plan has sparked unprecedented interagency cooperation, and [increased funding](#) for homeless programs to support these goals. Nationally, communities are reporting declines in unsheltered homelessness. In addition, the [research base](#) has grown significantly over the past ten years meaning we as a field now know much more about what works for people with different needs and strengths.

⁶ Brookings Institute, <http://confrontingsuburbanpoverty.org/> and Seattle Times, <http://www.seattletimes.com/seattle-news/poverty-hits-home-in-local-suburbs-like-s-king-county/>

⁷ Harvard Joint Center for Housing Studies, <http://www.jchs.harvard.edu/americas-rental-housing>

⁸ Institute on Taxation and Economic Policy, <http://www.itep.org/whopays/states/washington.php>

⁹ Brookings Institute, <http://www.brookings.edu/research/reports2/2015/03/city-inequality-berube-holmes>.

¹⁰ U.S. Interagency Council on Homelessness, *Opening Doors*, http://usich.gov/opening_doors/.

our neighbors in crisis

The prevalence of [homelessness](#)¹¹ is measured in two primary ways by All Home and its partners, both of which are requirements for all HUD Continuum of Care such as All Home:

- Homelessness Management Information System (HMIS), which collects data on the needs of consenting individuals seeking homeless services and measures their progress towards stable housing and other outcomes. All Home has designated the City of Seattle to administer HMIS, which is called [Safe Harbors](#).
- Point in Time Homeless Persons Count (PIT), which provide counts of sheltered and unsheltered people experiencing homelessness on a single night. All Home contracts with the Seattle-King County Coalition on Homelessness to conduct its PIT, called the [One Night Count](#), and All Home also conducts a specialized count of homeless youth and young adults called [Count Us In](#).

All Home measures its progress in ending homelessness by whether homelessness is rare, brief, and one-time. In addition, per this plan, All Home measures income progression and racial disparity.



How Many People Experience Homelessness?

Nationally, more than one million persons are served in HUD-supported emergency, transitional and permanent housing programs each year, and HUD estimates that the total number of persons who experience homelessness may be twice as high.

Local Point in Time Data: The [One Night Count](#) in King County tallied 3,772 people living unsheltered, on sidewalks, in cars, and tents on January 23, 2015. Another 6,275 people were in shelter or transitional housing and still considered homeless by HUD definition. [Count Us In](#) counted 134 unsheltered homeless youth/young adults, and a total of 824 unstably housed young people. Homelessness disproportionately affects King County's [non-white population](#).

Annual Data: [Safe Harbors](#) data shows 9,482 households utilized shelter and transitional housing in King County. Of these, approximately 50 percent were newly homeless (had not been served in our homelessness system in the past two years). As the charts on the following page illustrate, homelessness can affect anyone in our community, however, disparities exist, especially for people of color. (Source: 2014 Safe Harbors HMIS)



Homelessness disproportionately impacts people of color

Native Hawaiian/ Pacific Islanders

3 times more likely



African Americans

5 times more likely



Native Americans/ Alaska Natives

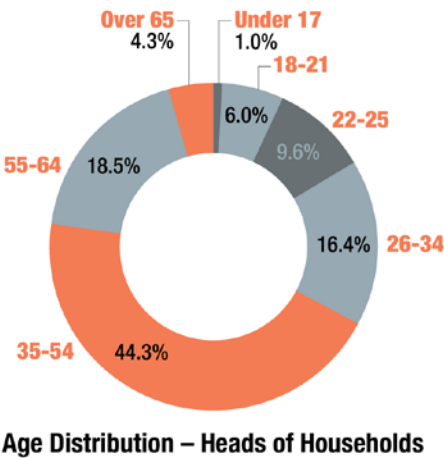
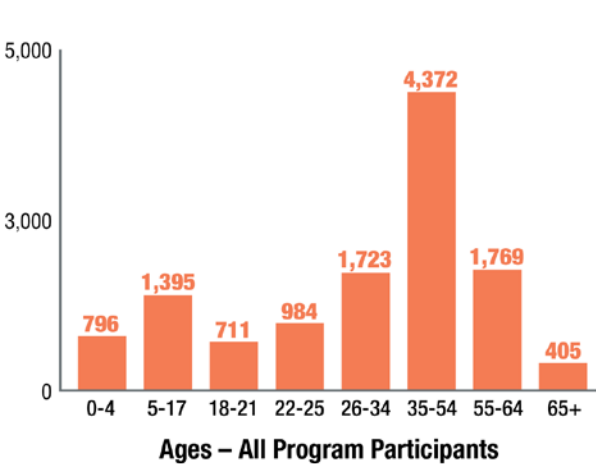
7 times more likely



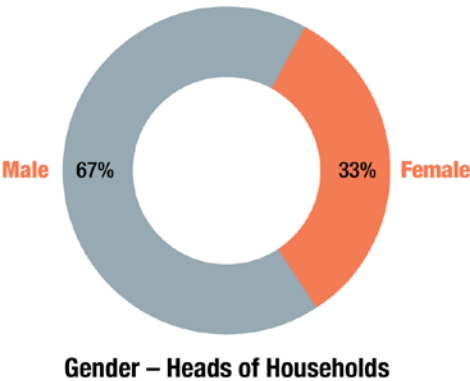
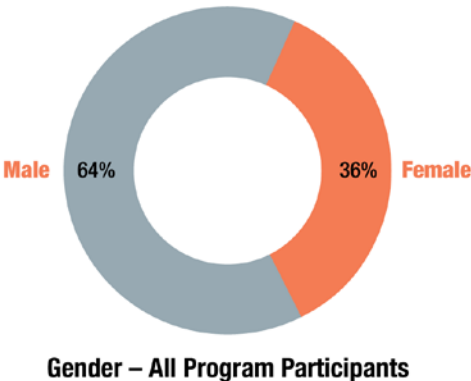
¹¹ There are four federally defined categories under which individuals and families may qualify as homeless: 1) literally homeless; 2) imminent risk of homelessness; 3) homeless under other Federal statutes; and 4) fleeing/attempting to flee domestic violence. Following HUD's guidance, All Home prioritizes those who are literally homeless.

Who's Homeless in King County

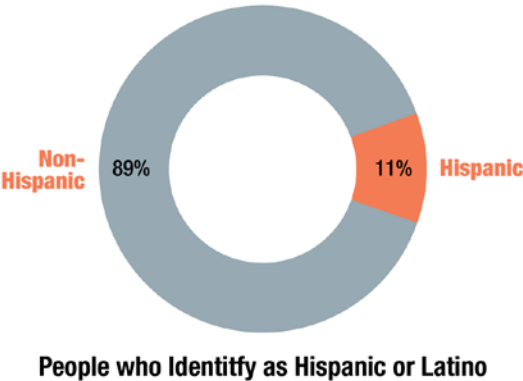
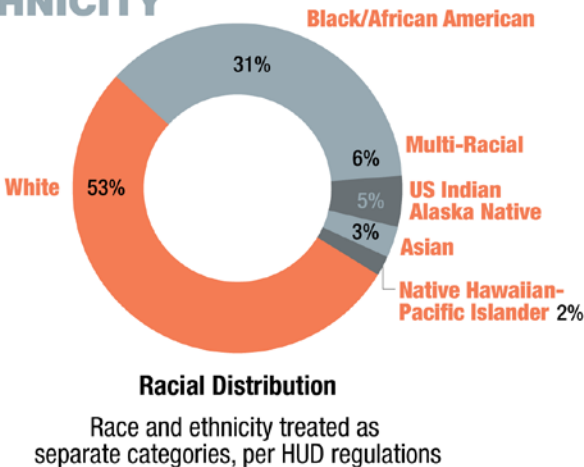
AGE



GENDER



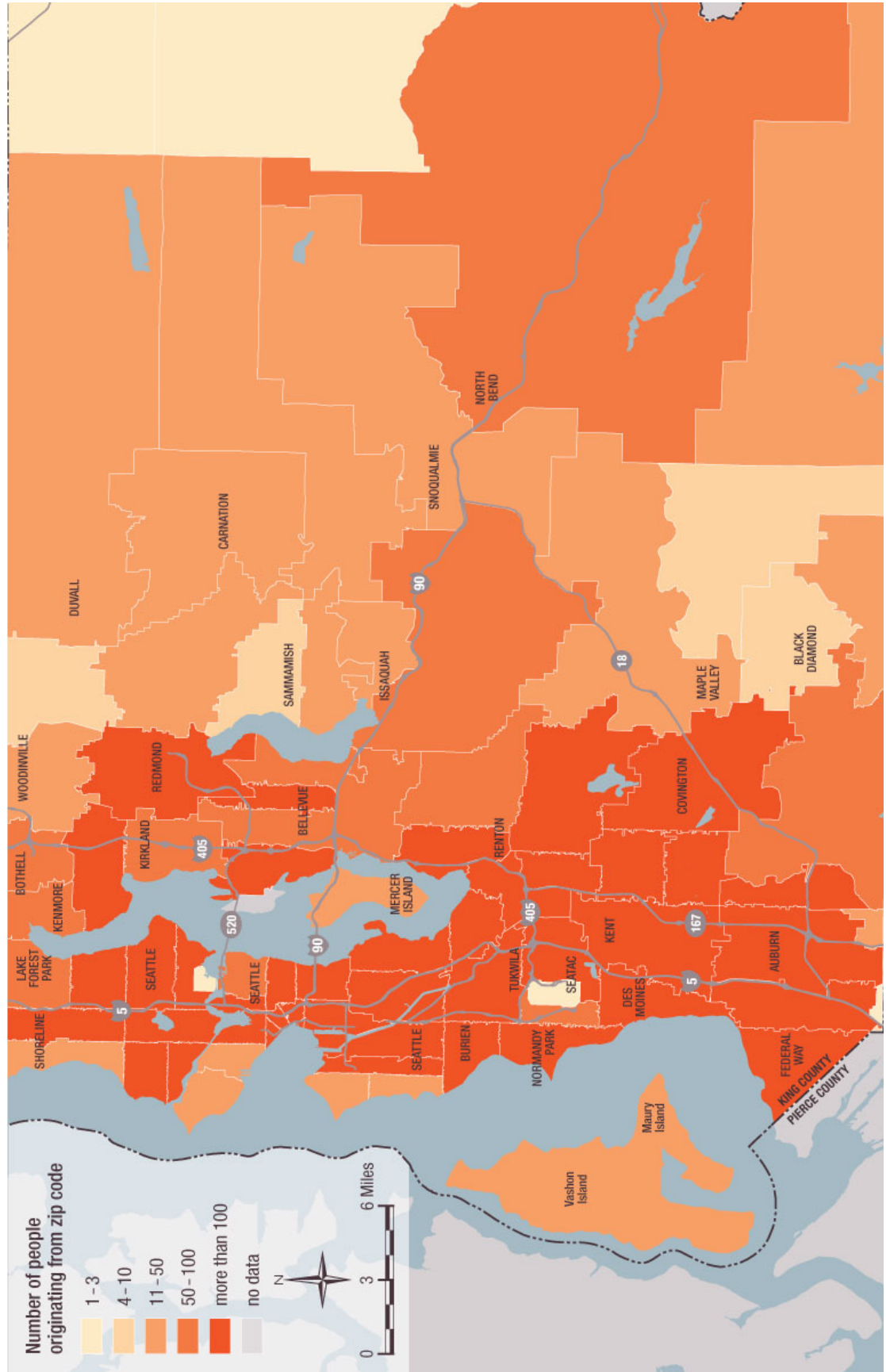
RACE/ETHNICITY



(Source: 2014 HMIS data)

Homelessness in our Region

People experienced homelessness in every zip code in King County last year, and 87 percent were originally from King County and 97 percent from Washington State. (Source: 2013 HMIS data)



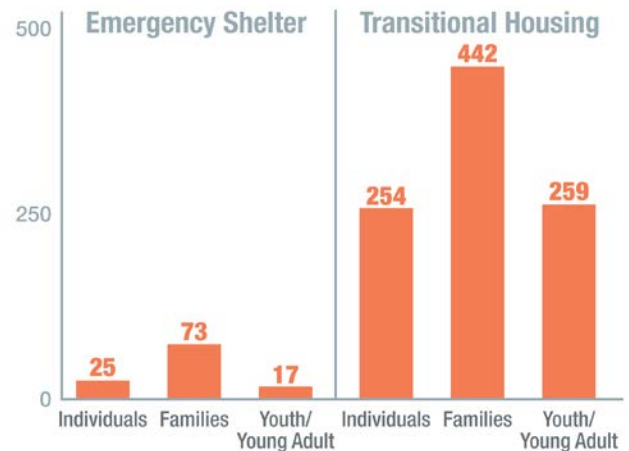


How Long are People Homeless?

Homelessness is **not brief enough** in King County: on average, in 2014, households experienced homelessness 100 days before finding permanent housing.

When homelessness is shortened, people are safer and more people can use limited resources. We have set a target of ten percent annual improvement in the length of episode of homelessness. The chart on the right shows the average length of stay in 2014 by intervention (days). (Source: 2014 HMIS data)

Length of Stay



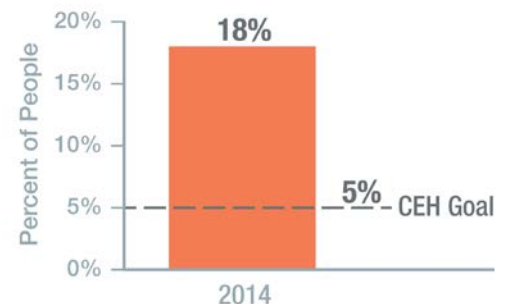
How Many People Are Getting Housed, and How Many Become Homeless Again?

In 2014, 2,071 households exited homelessness to permanent housing, an average of 173 per month.

However, too many people were homeless **more than one time**: about 18 percent of people who went from homeless to housed returned to homelessness within two years. (Source: 2014 HMIS data)

homelessness within two years. (Source: 2014 HMIS data)

Returns to Homelessness



When homelessness is a one-time only occurrence, people can stabilize and public services such as shelter, emergency rooms, and jails are less frequently accessed. We have set a target of ten percent annual improvement to reach our goal of five percent returns to homelessness.

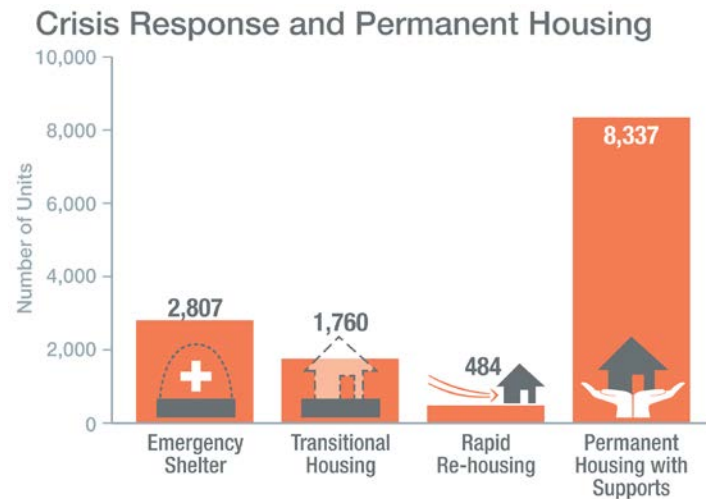
2014 Exits to Permanent Housing



our resources to address the crisis

Housing Resources

Through collective action since 2005, All Home dramatically increased the available resources for those experiencing homelessness in King County. This includes 6,314 units of permanent housing with supports funded since 2004, for a total of 8,337 units of permanent housing with supports countywide. King County's Continuum of Care (CoC) housing stock ranks third in the nation. Our system includes emergency shelter, transitional housing, rapid re-housing, and permanent housing with supports.



(Sources: King County/Seattle 2015 HUD Housing Inventory Count Data & Ten Year Plan Production Report 2005- 2014)

Top 10 Cities: # of Housing Units Dedicated for the Homeless

1. New York
2. Los Angeles
3. **Seattle/King County**
4. District of Columbia
5. Chicago
6. Boston
7. Philadelphia
8. Phoenix/Mesa/Maricopa County
9. San Francisco
10. Miami / Dade County

Financial Resources

In 2014, approximately \$42 million was invested in crisis response strategies to stabilize people currently experiencing homelessness in King County. Another \$116.7 million went to sustain formerly homeless individuals in permanent housing, assuring they don't return to the streets after exiting homelessness. An additional \$20 million in auxiliary services such as healthcare, treatment services, food, and employment/education services were provided to households but are not directly tied to homeless housing or homeless case management programs. These same types of services are often provided within the context of shelters and permanent housing stabilization programs, and in those cases the funding is reflected within crisis response and housing stabilization supports. The four charts on the following pages show the 2014 investments in housing and services dedicated to people experiencing homelessness.

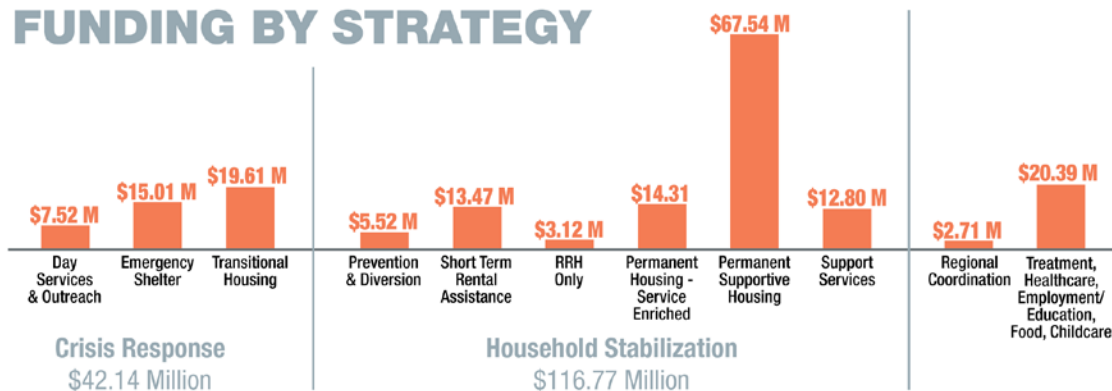
Information provided in this section is gained from the 'Systems Map', a bi-annual survey conducted in 2014 of local funding partners actively engaged in and leading All Home Initiatives. Investments reflect local, state and federal direct and pass through funds dedicated to homeless housing and services, and managed by these partners. Partners include: United Way of King County, Building Changes, King County and Seattle Housing Authorities, King County, City of Seattle and the Human Services Funding Collaborative¹² (an alliance of cities in King County), and direct funding from the US Department of Veterans Affairs and Housing and Urban Development. Other local governments also make funding commitments to address homelessness that are not reflected in this section.

In addition, a key component of our local efforts to end homelessness continues to be the strong commitment from our community partners, including congregations, businesses, and residents countywide. For example, many congregations provide volunteers, in-kind resources, land and buildings, in addition to broader advocacy and community efforts. We recognize this support is substantial; however, it is not represented in these charts.

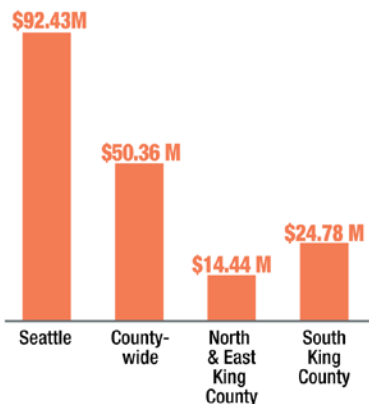
¹² The Human Services Funding Collaborative is an alliance of cities in East, North, and South King County. The participating cities include Auburn, Bellevue, Bothell, Burien, Covington, Des Moines, Federal Way, Issaquah, Kenmore, Kent, Kirkland, Redmond, Renton, Sammamish, SeaTac, Shoreline, and Tukwila.

Homelessness Investments 2014

FUNDING BY STRATEGY

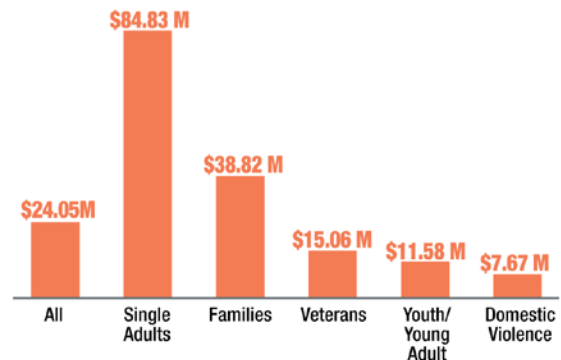


FUNDING BY AREA SERVED

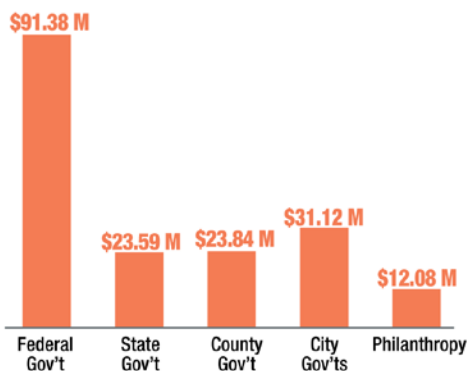


Notes: Funding by Area Served shows the location of the funding recipient (organization). Programs available to all residents in the county are categorized as countywide.

FUNDING BY POPULATION



FUNDING BY SOURCE



Federal	91.38	County	23.84
CDBG + HOME	3.79	General Fund + Special Projects	3.01
Health & Human Services	5.68	HOF/Doc Recording Fees	8.13
McKinney/Homeless Housing	22.91	Veterans & Human Services Levy	9.37
Public Housing	53.28	MIDD	2.60
VA	5.73	Other	0.73
State	23.59	Local	31.12
CHG	2.78	Seattle General Fund	15.23
HEN	13.16	Seattle Housing Levy	12.10
Medicaid + Match	6.82	Human Services Funding	3.79
Other	0.82	Collaborative General Fund	
		Philanthropy	12.08
		UWKC	9.16
		Building Changes, Gates, Raikes, others	2.92

Notes: See previous page for details on the data source for this chart. The Human Services Funding Collaborative resources on this chart only include general funds.

goals, strategies, and action steps

Make Homelessness



Make Homelessness

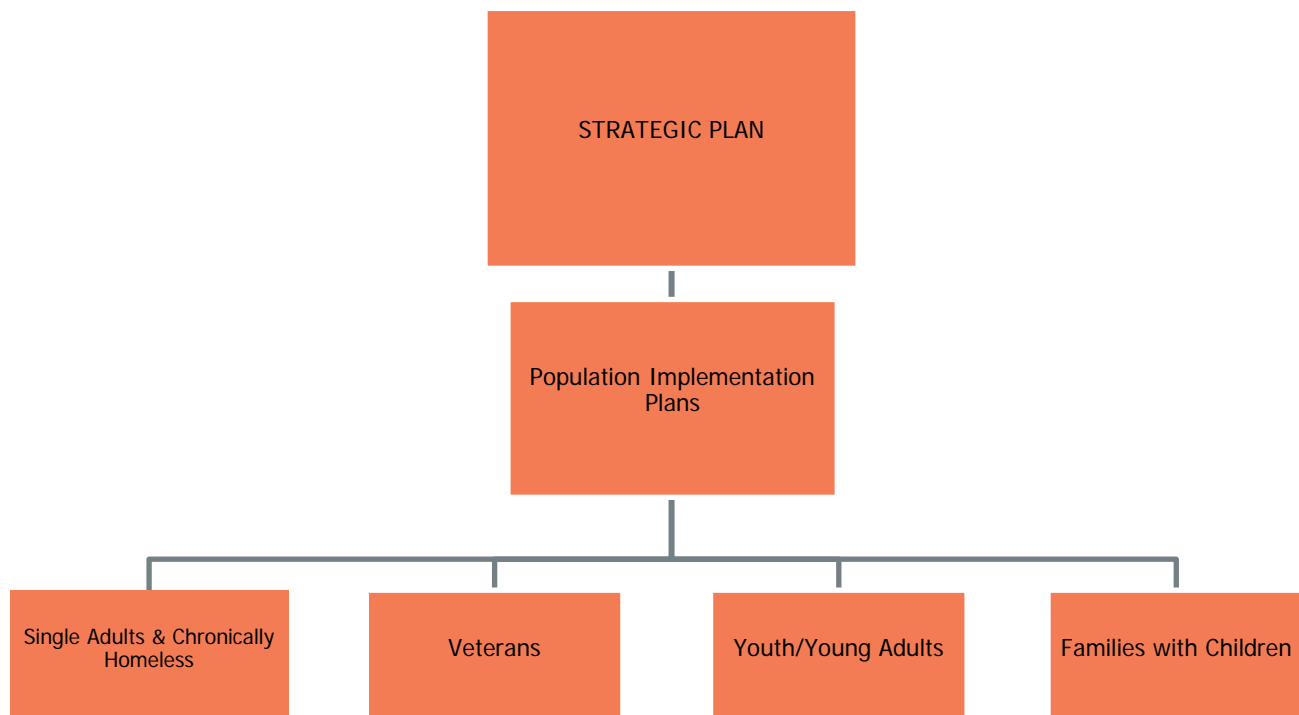


A Community to End Homelessness



The following strategies and action steps will guide the work of the All Home. Population-level implementation plans will further refine these strategies and action steps. These implementation plans will be amendments to this plan following adoption by the All Home governance committee over the course of the next several months.

Lead partners have been identified for 2015-2016 action steps. For those without a lead, no 2015-2016 action steps are included. For action on these items, lead partners must be identified. These strategies will be amended annually (for July-June) with action steps and reports on progress. Population-level work plans will also be updated annually in accordance with their adoption dates. Please refer to page six for additional information on the timing of the implementation plans by population.



goal 1: make homelessness rare



Making homelessness rare will require addressing the causes of homelessness, which are myriad and institutional. A 2013 national study found predictive factors for community rates of homelessness, including housing market, safety net, economy, demographics, and transience.¹³ The study found a 15 percent (metro areas) and 39 percent (nearby suburbs and rural areas) increase in homelessness per \$100 increase in median rent for the examined area. Seattle was the only large city where [rents jumped by more than \\$100](#) between 2010 and 2013. States with lower mental health expenditures were associated with higher rates of homelessness; in 2011, Washington ranked 47th in per capita psychiatric beds.¹⁴

Addressing and reducing homelessness will require **Federal and State action in addition to what we can control locally**. Seattle/King County has one of the largest stock of housing dedicated for people experiencing homelessness in the country. Meanwhile, the number of people living in poverty has grown, with sharp growth in poverty rates outside of Seattle.¹⁵

At the federal, state, and local levels, **increased affordable housing funding and policies are needed to support renters** who are experiencing homelessness to find and maintain housing. **Homeless prevention** strategies assist households in resolving a housing crisis that would otherwise lead to homelessness. In addition, targeting resources for those closest to homelessness has shown effectiveness. Medicaid, Temporary Aid to Needy Families (TANF), Food Stamps, SSI/SSDI, and behavioral health services are fundamental to housing stability for many, and connecting people to these services prevents homelessness and provides opportunities for others to get and stay housed.¹⁶

Housing stability is a common need among **individuals leaving jails, foster care, treatment programs and hospitals**, and refugees are at risk of homelessness upon termination of supports. Individuals with a history of incarceration were 7.6 times more likely to report experiencing adult homelessness.¹⁷ Alternative sentencing options and strategies that **stop the cycle of incarceration**, such as Therapeutic Courts (e.g. Drug Court, Mental Health Court, Family Treatment Court, etc.), [Familiar Faces](#), and Law Enforcement Assisted Diversion ([LEAD](#)), are promising local programs that address a significant cause of homelessness. People of color are also disproportionately represented in these systems. Each of our strategies must intentionally measure and direct action toward reducing these disparities.



how we'll know it worked

- ➡ Fewer people are unsheltered or temporarily housed
- ➡ Fewer people exit institutions directly to homelessness
- ➡ Racial disparities among people experiencing homelessness are reduced
- ➡ More people are housed and sheltered
- ➡ Fewer low-income households are spending more than half of their income for housing

¹³ Journal of Public Affairs, [New Perspectives on Community-Level Determinants of Homelessness](#)

¹⁴ Washington State Institute for Public Policy, [Inpatient Psychiatric Capacity in Washington State](#), 2011.

¹⁵ Brookings Institute, *Confronting Suburban Poverty in America*: [Seattle Times article](#) and [Brookings report](#).

¹⁶ U.S. Department of Housing and Urban Development, [Strategies for Improving Homeless People's Access to Mainstream Benefits and Services](#).

¹⁷ University of Pennsylvania, [Factors Associated with Adult Homelessness in Washington State](#), 2013.

strategy 1.1: advocate and align systems to prevent people from experiencing homelessness

- 1.1.A **Integrate prevention strategies in local homeless housing and service planning, and invest prevention resources in communities where the need and opportunity are greatest.** Success of prevention strategies requires targeting of resources to those most likely to become homeless. Strategies should test, evaluate, and refine targeting; have an explicit focus on addressing racial disparities; and target specific geographic areas.
- 1.1.B **Expand proven programs for connecting people exiting systems to housing.** Assure key systems (foster care, criminal justice, healthcare, mental health, refugee resettlement, other) incorporate discharge plans for housing within their support services. Share known best practices of proven discharge-planning models, advocate for necessary resources to incorporate or bring to scale discharge planning efforts, and test, learn and refine.
- 1.1.C **Collaborate with other mainstream systems including education, juvenile justice, foster care, and mental health** to address the urgent issue of YYA homelessness and prevent exits to homelessness for youth in care.
- 1.1.D **Advocate to the State for a stronger Interagency Council on Homelessness** commitment to preventing homelessness. Learn from states such as Utah, Minnesota, and Massachusetts that set state-level goals, and developed cross-system partners such as employment, criminal justice, physical and mental health, education, and entitlements. Set goals to increase access to cross-system services, reduce barriers to enrollment, and end related system exits to homelessness.
- 1.1.E **Assure availability of critical services frequently needed by** people with chronic disabilities and other vulnerable populations to enable them to live in stable community-based housing by advocating for funding and policies that reduce capacity barriers in other support systems. Provide professional development training to cross-system partners (criminal justice, behavioral health, healthcare, other) on best practices for serving people experiencing homelessness.
- 1.1.F **Advocate for secure sustainable funding to ensure sufficient, simplified access to behavioral health treatment** such as detox and outpatient psychiatric treatment and the integration of behavioral-physical health services. Support siting requests for new programs and services to assure regional distribution of housing and services.
- 1.1.G **Increase access to civil legal aid in situations where legal advocacy will prevent homelessness** (e.g. access to State and Federal benefit programs, SSI/SSDI, etc., foreclosure prevention, immigration, tenant representation, unemployment benefits, ABD, etc.).



2015-2016 action steps

- Continue the work of the Health and Human Services Transformation to make the shift from costly, crisis-oriented response to health and social problems to one that focuses on prevention, embraces recovery, and eliminates disparities. Specific initiatives include Familiar Faces, Communities of Opportunity, Physical/Behavioral Health Integration, and the proposed Best Starts for Kids levy. (Lead: King County; Quarter 4 2015)
- Organize efforts to support legislative action to strengthen State Interagency coordination. (Leads: USICH, All Home, other county leaders, State partners; 2016)
- Prevent homelessness among young people exiting foster care by applying for Youth At Risk of Homelessness implementation grant. (Lead; United Way of King County, Building Changes; Quarter 3 2015)

strategy 1.2: advocate and support partners to preserve existing and create more affordable housing for those making below 30% AMI

- 1.2.A Advocate for Federal, State, and local policies and funding to increase and preserve low-income housing** for households earning below 30% Area Median Income (AMI).
- Restore and increase federal support for low income housing development and operations through funding programs and retaining/strengthening the low income housing tax credit program.
 - Restore and increase Section 8 appropriations to expand both rental assistance programs and housing developments that serve households below 30% AMI.
 - Increase resources for State Housing Trust Fund and Federal Housing Trust Fund, and advocate for housing for those below 30% AMI.
 - Actively support local funding proposals including Seattle and King County levy renewals.
 - Encourage the use of a range of tools, policy, and land use regulations to increase the development of new affordable housing. Preserve existing affordable housing and address issues of substandard housing.
 - Assure policies and development address need for family-sized units, regional distribution, housing quality, and preservation of existing affordable housing
 - Tailor strategies at the regional level to emphasize preservation of affordable housing stock where it now exists and creation of new affordable housing stock where it is scarce.
 - Increase private sector involvement in creating more affordable housing.
- 1.2.B Increase access for people at risk of homelessness to existing affordable housing.**
- Increase resources for immigrants and refugees to mitigate the effects of restricted fund sources.
 - Ensure provision/coordination of services for those who need additional housing stabilization services.
 - Advocate for flexible policies to allow community and family supports in affordable and subsidized housing; ensuring need for services doesn't negatively impact eligibility.
 - Promote access to rental housing for those receiving housing vouchers. Strategies may include ordinances which bar landlords from discriminating against potential tenants who receive rental subsidies ("source of income discrimination ordinances").
 - Address policies for locally-funded rental assistance programs to ensure Housing Quality Standards do not create disincentives for Landlord participation.



2015-2016 action steps

- ➔ Establish and implement federal, state and local advocacy agenda to expand affordable housing. (Leads: WLIHA, HDC; 2015-2016)
- ➔ Pass the Seattle Housing Levy. (Lead: Seattle, HDC; 2016)
- ➔ Work with cities to encourage adoption and implementation of comprehensive plan Housing Element policies that support incentivizing new and preserving current affordable housing. (Lead: HDC; 2015-2016, ongoing)

strategy 1.3: expand evidence-based pre-adjudication and post-conviction sentencing alternatives that minimize involvement in the criminal justice system for people experiencing homelessness

- 1.3.A **Support the enhancement and expansion of pre-adjudication programs and sentencing alternatives** that help individuals avoid a criminal history while reducing criminal recidivism. Pre-adjudication programs, such as diversion courts and LEAD (Law Enforcement Assisted Diversion), and post-conviction sentencing alternatives can avoid incarceration, reduce recidivism, and reduce future homelessness by avoiding criminal convictions.



2015-2016 action steps

- ➔ Support efforts to secure sustainable funding for pre-adjudication programs and sentencing alternatives programs that help individuals avoid a criminal history while reducing recidivism. (Leads: King County, City of Seattle and local governments; 2015-16)
- ➔ Collaborate with Therapeutic Courts, Mainstream Courts, Familiar Faces, LEAD, and others partners, including partnerships identified and created under Strategy 2.2 to better integrate referrals and services among people experiencing homelessness. (Leads: King County, City of Seattle and local governments; 2015-16)

goal 2: make homelessness brief and one-time



To make homelessness brief and one-time, we must align funding and programs to support the strengths and address the needs of people experiencing homelessness. Shortening the length of time families and individuals are homeless reduces trauma and also creates capacity in our crisis response system for others in need. Ensuring that those we support to move to permanent housing do not become homeless again and return to our crisis response system also increases capacity of

crisis services to serve more individuals.

People will experience crises, and we must have resources available for them at these vulnerable times. This includes providing shelter, options for safe camping and parking, and coordination between law enforcement officers or other first responders and service providers. Local governments are responsible for ensuring public safety and public health, and maintaining public amenities for all residents, including those housed and homeless. Policies, practices, and ordinances that disproportionately impact people experiencing homelessness are costly and create barriers to [housing stability](#)¹⁸. For people surviving without shelter, these policies, practices, and ordinances may also exacerbate mental and physical health problems, create or increase criminal records, and result in the loss of key personal documents that make it even harder for people to exit homelessness. Approaches that foster collaboration between service providers and first responders, such as law enforcement, can do more to reduce homelessness.¹⁹

A well-functioning 'system' of providing housing and services to people experiencing homelessness is essential to making homelessness a brief and one-time occurrence. People who are homeless need homes and jobs. We need to better match people with the resources we have in our community, which includes at least \$160 million annually for programs for people experiencing homelessness (see page 13 for details on funding). We need to ensure we are delivering what people experiencing homelessness need in a cost-effective way. This enables our system to serve more people, while also ensuring people have companionship as they regain housing stability. The National Alliance to End Homelessness ([NAEH](#)) System Wide Analytics and Projections (SWAP) suite of tools will assist our community in using our local data to realign our funding and programming and to identify resource gaps, by program type and population.

Making large-scale changes to our system will require the entire funder and provider community to embrace an approach that focuses on safety, matching, immediate placement into permanent housing, and supporting stability through services and employment. Accurate information from people experiencing homelessness about their needs and satisfaction, regular analysis and continuous learning, capacity building, and a commitment to addressing regional and racial disparities are needed.



how we'll know it worked

- | | |
|---|---|
| ➡ People experience fewer days homeless | ➡ Incomes are increased |
| ➡ Fewer people lose housing stability | ➡ Racial disparities among people experiencing homelessness are reduced |

¹⁸ Seattle University School of Law's Homeless Rights Advocacy Project: <http://www.law.seattleu.edu/newsroom/2015-news/law-school-project-releases-briefs-critical-of-criminalizing-homelessness>

¹⁹ U.S. Interagency Council on Homelessness, *Searching Out Solutions*: http://usich.gov/resources/uploads/asset_library/RPT_SoS_March2012.pdf

strategy 2.1: address crisis as quickly as possible

- 2.1.A **Ensure sufficient shelter capacity**, including the preservation of existing shelter and increasing capacity to meet specific needs by population and region; including non-traditional shelter models that provide pathways to housing and interventions for long-term shelter stayers. Utilize National Alliance to End Homelessness tool to set system targets, which uses local data to make projections for system-level outcome improvements.
- 2.1.B **Increase support and community education for crisis response needs**, including interim survival mechanisms such as encampments, safe parking programs, and daytime/hygiene services that bring people out of the elements and create pathways to housing.
- 2.1.C Expand capacity to **divert people from shelter**, providing housing focused services prior to housing placement, including community-based strategies that provide (safe and appropriate) alternative options to shelter, creating a **“what will it take”** approach to get people on a **pathway into housing**.



2015-2016 action steps

- ➔ Expand shelter, interim survival mechanisms, and shelter diversion. (Leads: City of Seattle, King County, Building Changes, United Way, SKCCH, providers and sub-regional collaborations; 2015-2016)
- ➔ Implement McKinney bonus fund program for long-term shelter stayers. (Leads: All Home, City of Seattle; 2015-2016)

strategy 2.2: foster collaboration between first responders, service providers, and local communities to increase housing stability for those experiencing homelessness

- 2.2.A **Solicit information from local governments, including human services staff, law enforcement, and other first responders about existing partnerships with service providers and innovative approaches to assist those in need of housing**. Develop new, and boost existing, partnerships between behavioral health and social service providers, neighborhood associations, and local governments, including law enforcement and other first responders. Engage partners in proactive strategies that link individuals who are homeless with housing and services with the additional goal of reducing criminal justice system involvement. Ensure adequate resources are available for proactive and consistent outreach efforts.
- 2.2.B Provide support to local governments to undertake an **impact analysis of local policies, practices, and ordinances that disproportionately impact those experiencing homelessness**, and the costs and consequences to residents (housed and homeless). The review could also include identification of gaps in services and a cost/benefit analysis comparison of alternative approaches.



2015-2016 action steps

- ➔ Host a convening, and disseminate case studies on best practices for **collaboration between first responders and service providers** to increase housing stability for those experiencing homelessness. As a potential outcome of the convening, a toolkit for local neighborhoods may be created. (Leads: SCA, All Home; Quarter 4 2015)
- ➔ Pilot a voluntary **impact analysis of policies, practices, and ordinances in one to two communities**. Through this analysis, local governments will be able to identify policies, practices, and ordinances that create barriers for those experiencing homelessness and implement changes to support housing stability for all residents (housed and homeless) in their communities. (Lead: All Home: Quarter 1 2016)

strategy 2.3: assess, divert, prioritize, and match people with housing and supports

- 2.3.A Ensure there is a **coordinated assessment system that is equipped to assist in appropriately identifying and prioritizing candidates for the right housing** and services intervention by using a progressive engagement approach and diverting people from shelter where possible.
- 2.3.B Integrate into the coordinated assessment process a standardized employment readiness assessment that leads to **appropriate linkages with employment services**.
- 2.3.C Ensure admission criteria for homeless housing programs reflects **Housing First practices** (reducing criteria based on income, disability, treatment compliance, criminal histories, etc.) while ensuring agencies have the capacity to provide appropriate services for the target population.
- 2.3.D **Improve access to civil legal aid** to assist populations facing disproportionate levels of homelessness in King County in accessing state and federal benefit programs. Explore 'no cost' strategies that provide better integration of existing structures for improved coordination and elimination of silos that create structural barriers. Identify civil legal organizations in King County that can partner with homeless housing providers to deliver civil legal aid to people facing civil legal barriers to obtaining or maintaining access to housing.



2015-2016 action steps

- ➔ Implement all-population coordinated entry system using progressive engagement approach. (Lead: Multiple partners; ongoing improvements in 2015, full implementation by Quarter 2 2016)

strategy 2.4: right-size housing and supports to meet the needs of people experiencing homelessness

- 2.4.A Commit to **right-sizing our homeless housing stock and services** based on typology and needs throughout the system so we can house more people; utilize National Alliance to End Homelessness tool to assist in setting system targets.
- 2.4.B **Increase rapid re-housing** opportunities to enable people to locate housing and exit homelessness quickly.
- 2.4.C **Increase Permanent Supportive Housing (PSH)** for those who are chronically homeless:
- Sustain and increase availability throughout King County through new housing development and rental assistance models.
 - Optimize utilization (examples: prioritizing admission for those with the highest needs; enable residents to move to less or more service-intensive housing based on identified need).
 - Identify appropriate and sufficient services funding to ensure housing stability in PSH (e.g. mainstream sources such as Medicaid).
 - Plan with Seattle Housing Levy to increase PSH.
- 2.4.D **Convert transitional housing** stock to support rapid placement in permanent housing. Some limited transitional housing will remain to serve specialized populations that would benefit from the model.
- 2.4.E Increase the capacity of providers to implement **tailored services**; utilizing **progressive engagement** and **Housing First** practices that are flexible and responsive to the needs and priorities of individuals. Ensure support for culture shift for providers.
- 2.4.F Ensure **culturally appropriate, tailored, and responsive services** / relevant pathways out of homelessness. Ensure that the right amount of the appropriate services is available to maintain housing in a culturally appropriate way.
- 2.4.G Ensure homeless **housing stock and services are geographically located** to allow, whenever possible, for the need of individuals and families to be met in their own communities.



2015-2016 action steps

- ➔ Continue right-sizing, including family transition housing conversion underway and young adult typology analysis. Utilize NAEH modeling tool to assist in determining right-size of each housing model and resource gaps, including racial and geographic, to include in population implementation plans and establish future state targets. (Lead: Funders Group; analysis by Quarter 4 2015)

strategy 2.5: increase access to permanent housing

- 2.5.A **Increase access to private market housing opportunities by expanding coordinated, countywide, landlord outreach / engagement strategies** to recruit private market rental partners. Expand One Home landlord engagement campaign with additional incentives and marketing. Incentivize the reduction of screening criteria that screens out prospective tenants with evictions, poor credit, and/or criminal histories.
- 2.5.B **Increase access to housing opportunities by expanding permanent housing options** that may be less expensive, such as shared housing, host homes, boarding houses, and SROs.
- 2.5.C **Increase availability of subsidized low income housing** that is set-aside for people experiencing homelessness.
- 2.5.D **Increase access to subsidized low income housing** that is not set-aside for people experiencing homelessness; examples include decreasing tenant screening barriers and implementing homeless preference in low income federally subsidized housing.



2015-2016 action steps

- ➔ Expand One Home landlord engagement campaign with additional incentives and marketing. (Leads: All Home, Zillow, United Way; Quarter 4 2015, ongoing)

strategy 2.6: create employment and education opportunities to support stability

- 2.6.A **Recruit more businesses to train and hire people who have experienced homelessness** to increase capacity to assist people in accessing employment and increasing income.
- 2.6.B **Increase access to employment programs through employment navigation services**, which support people experiencing homelessness (including youth and young adults) to increase and sustain income through employment.
- 2.6.C **Integrate financial empowerment strategies into housing services** to improve financial stability (e.g. money-management advice and coaching).
- 2.6.D **Increase access to appropriate services to gain and sustain employment and education opportunities**, such as childcare (or financial assistance for childcare).
- 2.6.E **Formalize cross-system agreements to improve access to employment and education programs, and outcomes of people experiencing homelessness** by developing State and local level memorandum of agreement, and include agreements regarding leadership, staff training, goals and outcomes.
- 2.6.F **Improve data collection on the employment and education needs and outcomes** of people experiencing homelessness.



2015-2016 action steps

- ➔ Integrate employment and education program access into coordinated entry (Leads: All Home, Workforce Development Council, City of Seattle, United Way, Building Changes, provider partners; 2015-2016)

goal 3: a community to end homelessness



It will take the entire Community to End Homelessness. All partners must be aligned if we are to meet the goals of this plan, and a new level of engagement and accountability among all sectors is needed.

Awareness and engagement of residents of King County will support our goals of making homelessness rare, brief, and one-time in King County. Efforts like the [Rethink Homelessness](#), [Invisible People](#), and locally, [Facing Homelessness](#), [Firesteel](#), and Seattle University's [Project on Family Homelessness](#) are effective at changing perception and sparking action by individuals. Connecting housed residents with those experiencing homelessness, through crowdfunding and companionship, is a promising approach to activating our community to advocate for systemic change while

making a difference in real person's lives immediately. Building community among the partners working to end homelessness, and celebration is key to weaving together this community of committed champions.

Instead of asking business leaders to attend meetings and provide input, we need to maximize their contributions by providing concrete opportunities to support the goals of this plan, including job creation, housing access, and state and local policy changes. Communities, such as [Los Angeles](#), that have strong **business community partnership** in efforts to end homelessness are providing leadership opportunities for business partners.

For decades, a strong component of our community efforts to end homelessness has been the **strong commitment of congregations** countywide. Multiple organizations have organized and supported congregations. Many congregations have provided land and buildings, led local and state advocacy, increased community awareness, and provided jobs and housing. These efforts need ongoing support to expand and allow for more congregations to contribute.

We have learned that effective collaboration is an ongoing process that never truly ends. Accomplishing community-level outcomes, such as ending homelessness, requires a **strong infrastructure and shared accountability**. Our current charter and governance structure is overly complicated, and decision-making has become diffused among too many committees. Community-based governance equipped with decision-making authority will provide oversight and leadership for the implementation the plan.

Adoption of this plan enacts a process to establish a **new governance structure** for All Home. The Governing Board and Interagency Council will be consolidated into a single "Coordinating Board". Membership will be representative of our county and people who are experiencing homelessness. Formal agreements must be reached among partners to ensure accountability and results. The voluntary adoption of a memorandum of agreement among participating funding partners will also establish funding alignment and commitment to achieving community-level outcomes. The memorandum will define roles of authority, establish system infrastructure staffing responsibilities, and provide clarity of commitment among partners to achieving the goals of the plan. Additionally, to successfully implement this plan, infrastructure, including staffing, capacity building for providers, database management, evaluation, and advocacy, are necessities.



how we'll know it worked

- | | |
|--|--|
| ➡ Increased engagement of residents | ➡ Effective and efficient governance and system infrastructure |
| ➡ Increased leadership of business and faith leaders | |

strategy 3.1: engage residents, housed and homeless, to take community action

- 3.1.A **Launch an ongoing community-wide public awareness and engagement campaign** to provide opportunities for action and compassion among all residents, housed and homeless. Create opportunities for action through advocacy, volunteerism, donations, and more. Develop multiple forms of media and hold regular community forums. Connect housed residents with those experiencing homelessness, through crowdfunding and companionship. Find ways to link individual stories that agencies are producing already, and take advantage of affordable housing forums, neighborhood organizations, candidates forums, and other existing venues.
- 3.1.B **Create a business leaders task force** to establish goals and strategies for the business community to support the strategic plan. Areas of focus for the task force could include fundraising, advocacy, job creation, and housing access.
- 3.1.C **Increase visibility and expand efforts of successful initiatives that engage faith** institutions and individual congregants, particular focus could include advocacy, recruitment of landlords, and hosting of day centers, meals, shelter, and encampments.



2015-2016 action steps

- ➔ Launch an ongoing community-wide public awareness and engagement campaign to provide opportunities for action and compassion among all residents, housed and homeless. (Leads: All Home with communications partners; Quarter 4 2015)
- ➔ Create a business leaders task force to establish goals and strategies for the business community. (Lead: UWKC; Quarter 4 2015)
- ➔ Increase visibility and expand efforts of successful initiatives that engage faith institutions and individual congregants; consider convenings where faith leaders can work with All Home on how they might more cooperatively and effectively undertake various initiatives on homelessness and housing. (Lead: Seattle University; Quarter 4 2015)

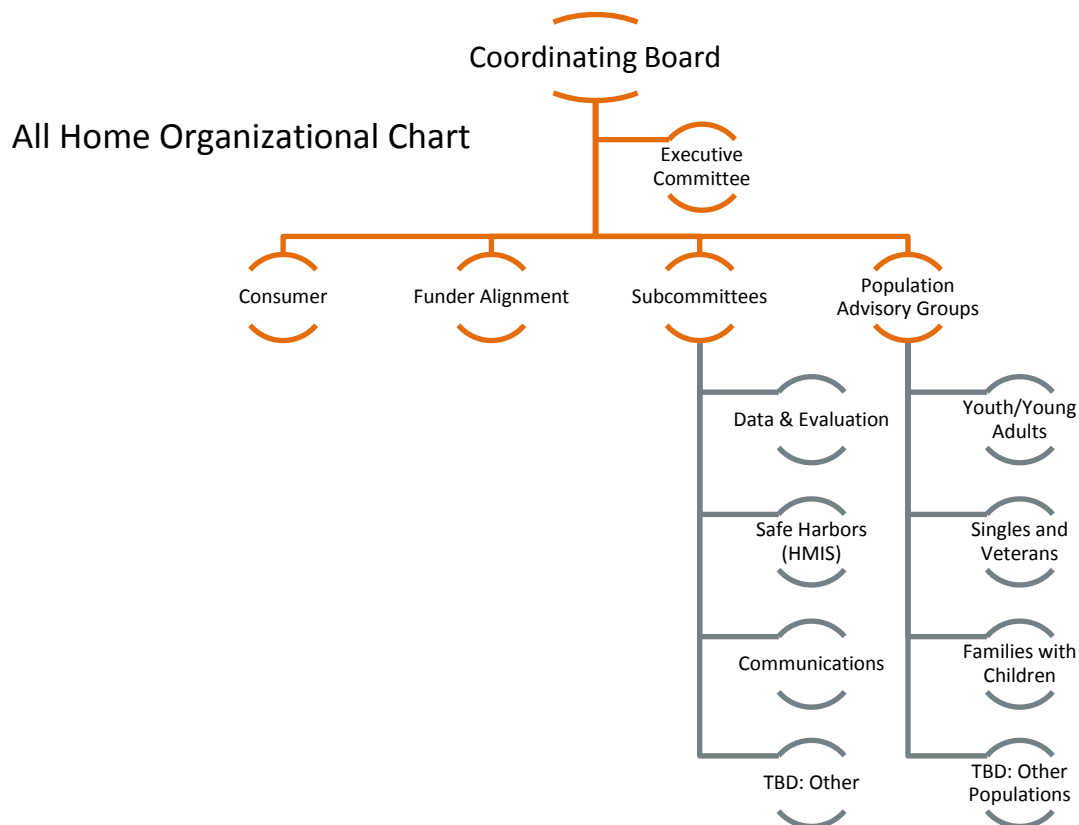
strategy 3.2: provide effective and accountable community leadership

- 3.2.A **Establish a single “Coordinating Board”**, consolidating the existing Governing Board and Interagency Council. The role of this body will be:
- Providing oversight and leadership for the implementation of this plan
 - Organizing to provide for a system of housing and services to address the needs of people experiencing homelessness in King County
 - Ensuring accountability for results
- 3.2.B **Engage local governments, philanthropic organizations, and community partners** in the development and voluntary adoption of a Memorandum of Agreement to assist in implementing this plan including voluntary alignment of funding and commitment for community-level outcomes. The MOA shall define roles, establish system infrastructure and staffing responsibilities, and clarify commitments towards achieving the goals of this plan.
- 3.2.C **Build community among partners by recognizing successes** through social media, blogs, reports, regular convenings, and an annual All Home meeting.



2015-2016 action steps

- ➔ Establish new governance structure (see All Home Organizational Chart below) through the adoption of a revised All Home [Charter](#). The existing All Home Executive Committee (see beginning of plan for member names) will serve as the transition committee. Applications for membership to the new “Coordinating Board” will be open to the public. (Lead: All Home Coordinating Board; Quarter 3 2015)
- ➔ Develop MOA among funding partners. The MOA shall define roles, establish system infrastructure and staffing responsibilities, and clarify commitments towards achieving the goals of this plan. (Lead: All Home Coordinating Board/Executive Committee; Quarter 4 2015)



Appendix A: Performance Measures and Dashboards



King County has been actively pursuing system-wide measurement in full alignment with the HEARTH Act. The HEARTH selection criteria are an elegant and powerful set of key indicators that focus on ending homelessness.

Data and Evaluation Workgroup

Several years ago, All Home tasked the Data and Evaluation Workgroup to coordinate the data and evaluation work being done system-wide, and to catalogue and communicate data via regular communication with the public and All Home governance structure.

The Data and Evaluation workgroup is responsible for systems-level performance measurement, for example, but not limited to:

- Report on the HEARTH performance measures (including system-wide annual dashboard; see page 28).
- Report on performance by population, program type, and program-level performance.
- Recommend performance targets consistent with the Strategic Plan and system vision for each program type and subpopulation. (See 2015 contract targets on page 29.)
- ➡ Monitor programs receiving HEARTH funding; track performance, evaluate outcomes, and recommend actions to improve performance of or reduce funding for poor performers.

Reporting Progress-Strategic Plan Action Steps

The Coordinating Board will receive regular progress reports on the status of each Action Steps and future, the identified “Leads” will be responsible for this reporting process. This may include a standardized performance management tracking tool that indicates key work items, milestones, progress to date, etc. Below is a sample format²⁰.

Council Performance Management Plan Tracking Worksheet

Obj.	Reporting Agency or Group	Milestone/Measure	Description	Target Date	Update (January 1 - June 30 2014)	Status

Lead Reporting Agency or Group - The interagency workgroup(s) or agencies responsible for updating the progress of the milestone.

Milestone/Measure - Indication whether the item is a milestone or measure.

Description and Target Date - The description of the milestone or measure and, in the case of a milestone, the target date.

Update - The space where the reporting interagency workgroup or agency provides a semi-annual update.

Status - The space where the reporting interagency workgroup or agency provides the status of the milestone or measure, from the drop down list of available options:

- Action Completed
- Substantial Action
- Minimal Action
- No Action
- Infeasible
- N/A

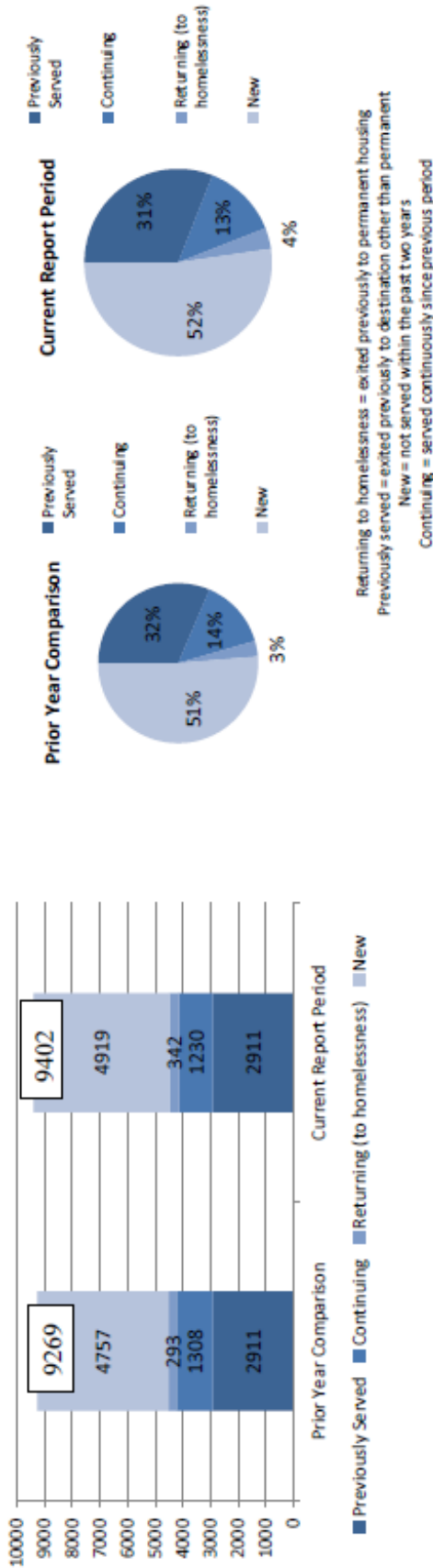
Annual Report

All Home will produce an Annual Report that will be shared at the CoC Annual Conference. The goal of the Annual Report is to provide an overview of the our community’s strategic approach and the results of the previous year in making homelessness rare, brief and one-time.

²⁰ USICH Council Performance Management Plan Tracking Worksheet 2014.

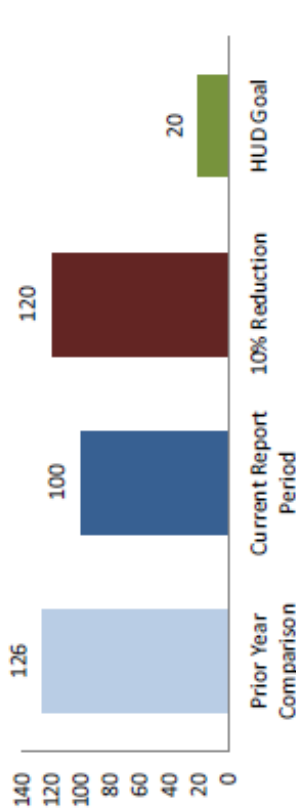
HEARTH Performance Measures for Ending Homelessness in King County **January 2014 – December 2014** **System Measures:** HEARTH measures consider the homeless system as a whole, including emergency shelter (ES) and transitional housing (TH) across all populations

"RARE": Number and Proportion of Households Served in Emergency Shelter and Transitional Housing



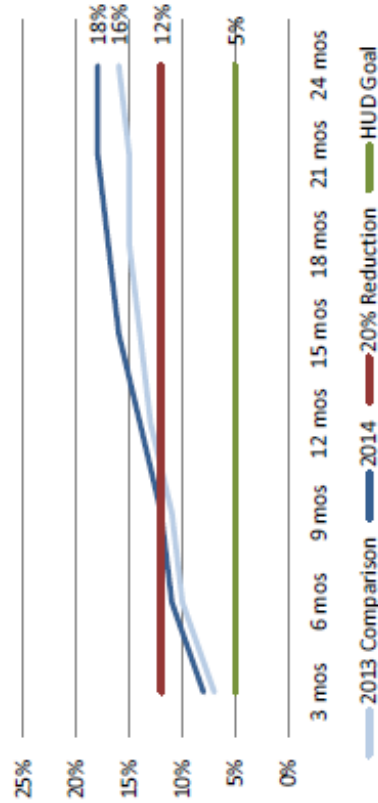
One Night Count In January 2015, more than 3,772 individuals were living outside and another 6,275 individuals were in shelters or transitional housing, per the One Night Count conducted by the Seattle/King County Coalition for the Homeless.

"BRIEF": Average Days in Emergency Shelter & Transitional Housing



1435 households exited to permanent housing between 1/2014 and 12/2014 (compare to 1419 for one year period 1/2013 to 12/2013)

"ONE-TIME": Cumulative Returns to Homelessness after Exiting to Permanent Housing



Note: Charts reflect identified data only.

CEH System Performance Measures – DRAFT 2015 Contract Targets

IAC approved crisis response system targets September 2014, confirmed by population initiatives and Data & Evaluation Workgroup.

For IAC Approval at November 2014 meeting: targets discussed and presented at September 2014 IAC meeting and vetted by Data & Evaluation Workgroup, to be vetted by population initiatives at October meetings.

	System-Wide Goal	Emergency Shelter	Transitional Housing	Safe Haven	PH: Rapid Rehousing	PH: Permanent Supportive Housing	PH – Housing Only	PH – Housing with Services	Street Outreach	Services Only	Prevention
Number of Homeless Persons: Annual & Point in Time	Decrease overall number of sheltered & unsheltered										
Number of Persons Who Become Homeless for the First Time											
Exits to Permanent Housing	Increase exits to permanent housing	YA 10%; Y 33% Singles overnight 5% Singles case managed 20% Families 33%	YYA 64% Singles 70% Families 80%		80%				Success = exits to PH, some institutional destinations & temporary destinations (not PNMHH)		90%
Exit to or Retention of Permanent Housing	Increase retention and exits to PH					92%					
Length of Time Persons Remain Homeless	Decrease to 20 days on average	YYA 20 days Singles 37 days Families 100 days	YYA 275 days Singles 325 days Families 390 days								
Returns to Homelessness (at 6, 12 & 24 months)	Decrease to 5% within 24 months	YYA 30% Singles 15% Families 5%	YYA 15% Singles 7% Families 7%		10%	10%					7%
Employment and Income Growth for Homeless Persons	Increase employment and non-employment cash income										
Process/Efficiency Measures											
Occupancy											
Data Quality											

LEGEND: Yellow highlighting = Measures that are the focus of performance targets for 2015 contracts – exits to permanent housing, length of stay and returns to homelessness.

Grey boxes = No HUD system performance measure set in new HUD guidance released July 2014.

White boxes = HUD system performance measures required for this type of program, if blank, system target not set by our local community.

Appendix B: Predictive Modeling

In the last several years, national leaders in data and evaluation have developed analytics and projection tools designed to use local data to inform system planning and change efforts. These data-driven tools are assisting communities in creating a very detailed vision of a homelessness system that works by providing a roadmap that identifies changes that will help reduce homelessness the most.

System-Wide Analytics and Projection (SWAP) Suite of Tools is a joint project of [Focus Strategies](#) and the [National Alliance to End Homelessness](#) (NAEH)²¹. SWAP is designed to enable communities to use local data to understand what their current system is accomplishing, and model what happens when system and program changes are made. The SWAP tools can be used to inform system planning and system change efforts to reduce homelessness over a period of up to five years.

SWAP uses concepts found in earlier predictive modeling tools but adds in a number of additional features to make it more powerful for specific system planning purposes. The SWAP analyzes system performance at a program-by-program level and allows communities to model the results of changes to individual programs or groups of programs. These can include such strategies as re-allocation of funding from transitional to rapid re-housing, serving more literally homeless people in existing programs, or increasing the rate of exit to permanent housing. The SWAP will also model the impact of creating new programs through new investments.

One of the most powerful outputs of the SWAP is an estimate of how the size of a community's homeless population will change over a five-year period as a result of the programmatic and investment changes being modelled. Communities can use this tool to assess the impact of policy changes they may be considering or to see how changes already implemented could pay out. The SWAP allows communities to compare the pros and cons of different approaches and can help leaders and policy makers choose a strategic direction that will have the greatest impact on reducing homelessness. For example, the tools allow users to adjust and model elements of homeless systems including:

- System elements: population size, new entries into homelessness, investment and capacity changes, program performance
- Strategy foci: shifting investments, diversion, increasing utilization, reducing length of stay, increasing exits to permanent housing, reducing returns

Things to know about the system performance predictor tool:

- ➔ Very powerful tool to drive systems change conversations
- ➔ It relies on base year calculator data (local HMIS data)

What we'll get:

- ➔ User-friendly and transparent systems modeling
- ➔ Ability to quickly model many different scenarios

Start Year X

2014 Annual Investment in the Homeless System of Care
CoC-123: Anytown USA

	Emergency Shelter	Transitional Housing	Safe Haven	Rapid Rehousing	Permanent Supportive Housing	Total
Beds for Adult Only HHs:						
Public Dollars	\$0	\$1,376,881	\$0	\$0	\$17,460,952	\$18,839,833
Private Dollars	\$5,467,473	\$0	\$0	\$0	\$1,740,799	\$7,444,301
Total investment	\$5,467,473	\$1,376,881	\$0	\$0	\$19,201,751	\$26,284,134
Units for Family HHs:						
Public Dollars	\$0	\$2,896,044	\$0	\$0	\$2,579,593	\$5,475,637
Private Dollars	\$30,863	\$4,562,247	\$0	\$0	\$248,542	\$4,841,652
Total investment	\$30,863	\$7,458,291	\$0	\$0	\$2,828,135	\$10,317,289

focus STRATEGIES FocusStrategies.net

Year X Planning

System Planning Tool

The purpose of the SPP is to help communities design a system that is sufficient to ensure that no one is homeless more than 30 days. Ultimately, the goal is that all homeless people and families are permanently housed. As an interim step, however, some may require temporary shelter while they secure permanent housing. This worksheet is intended to serve as a general orientation to the types of system changes that can impact a community's ability to house the most homeless people and families in the shortest amount of time. The sheet below estimates the number of unsheltered persons and families that "need" temporary housing. The word "need" is being used loosely to equate to the number of people who are sleeping outside and do not have shelter; ultimately, all homeless persons and families "need" permanent housing, not temporary shelter.

Over the course of 2014, Anytown USA had 4,788 unsheltered households: 4,718 unsheltered adult only and 30 unsheltered family households (A). Anytown USA also had an annual capacity of 119 permanent housing units available (B), leaving 4,629 unsheltered households needing a temporary housing solution.

(A) Annual unsheltered homeless population, 2014:		
Adult Only Households	4,718	
Family Households	30	
Total	4,788	
(B) Annual permanent housing capacity for unsheltered households, 2014:		
Adult Only Households	206	
Family Households	13	
Total	219	

(C) 4,629 unsheltered households needing temporary housing in 2014

If every unit of ES, SH, and TH in Anytown USA operated at a 95% utilization rate with 90% of their entries for unsheltered households and had a 30 day length of stay, Anytown USA would need a total of 445 units of ES, SH and TH to serve the unsheltered population.

Capacity needed to serve the Unsheltered Population =
 $\text{annual HHs needing shelter} = ((305 \times \text{utilization rate} \times \text{rate of entry from unsheltered}) \div \text{length of stay})$
 $445 = 4,629 \text{ annual HHs needing shelter} \div ((305 \times 95\% \times 90\%) \div 30 \text{ days})$

Anytown USA currently has 1,063 units of ES, SH, and TH.

Adding new units, increasing utilization, decreasing length of stay, and increasing the percentage of unsheltered households that can have substantial impacts (independently as well as in combination) on the ability to ensure that nobody is homeless longer than 30 days. The next table allows estimation of the aggregate impact of program design and operation on temporary shelter (ES, SH, or TH) and permanent housing (RHH and PSH) availability such that households are not homeless longer than 30 days. Input data in the yellow cells to adjust one or more of these figures and see the potential impact on the homeless population (the yellow cells on annual capacity is populated with the current capacity per the HIC, but can be adjusted). This worksheet is intended to give the user a general understanding of what changes will have the biggest impact in their system, and to set the stage for project specific modeling.

²¹ [Focus Strategies](#), in collaboration with NAEH, developed a suite of tools they call System Wide Analytics and Projection (SWAP) Tools. <http://focusstrategies.net/swap/>

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All Home

All Home

ALL HOME is a community-wide partnership to make homelessness in King County rare, brief and one-time.

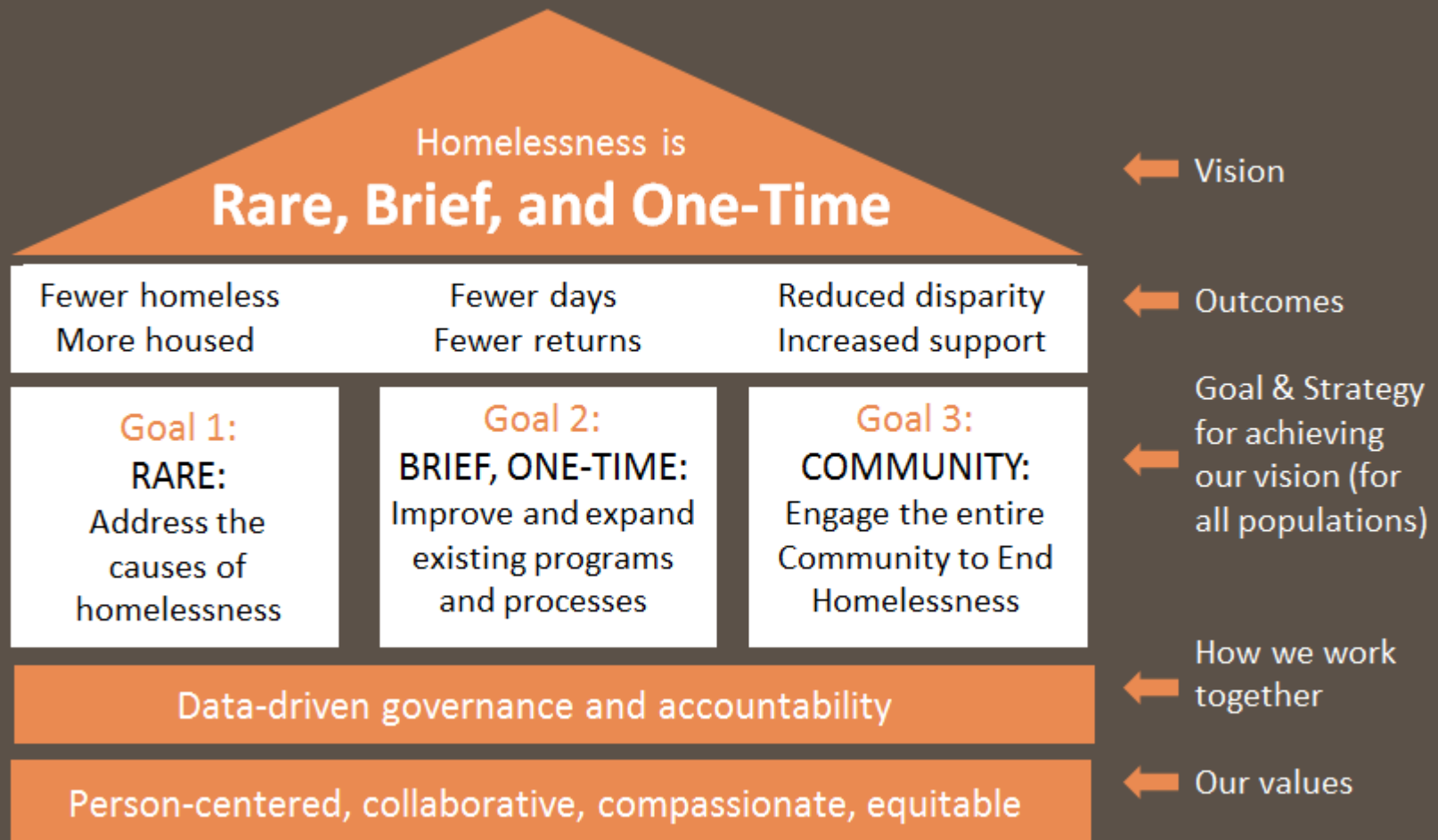


4 Year Strategic Plan

*A Regional, Aligned, Community Plan
to End the Experience of Homelessness
among Residents of Seattle/King County*



4 Year Strategic Plan



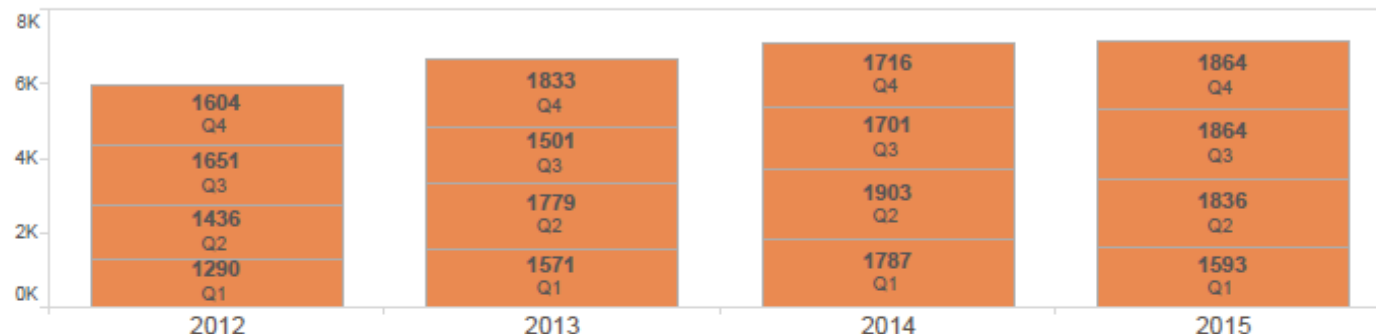
KING COUNTY SYSTEMS PERFORMANCE 2015

ALL POPULATIONS



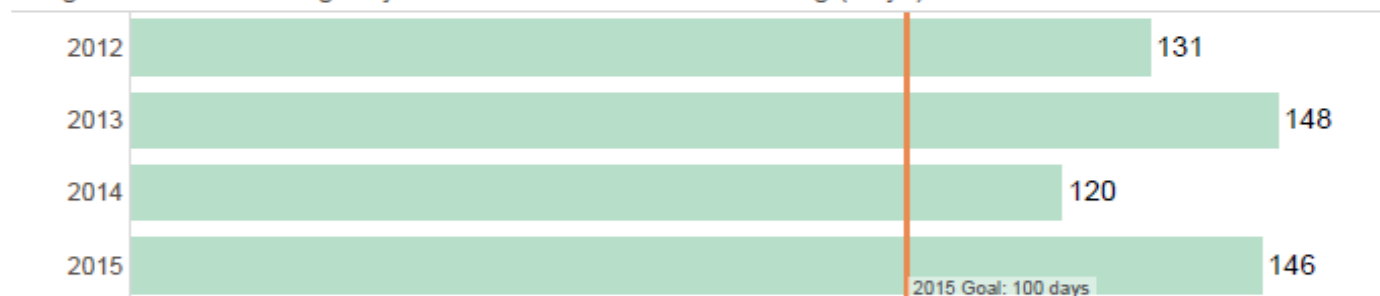
RARE

Number of Households Housed



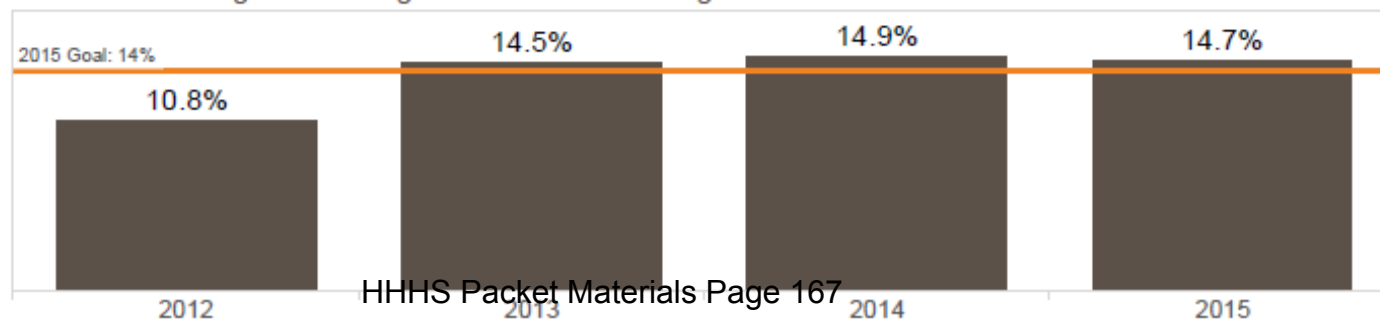
BRIEF

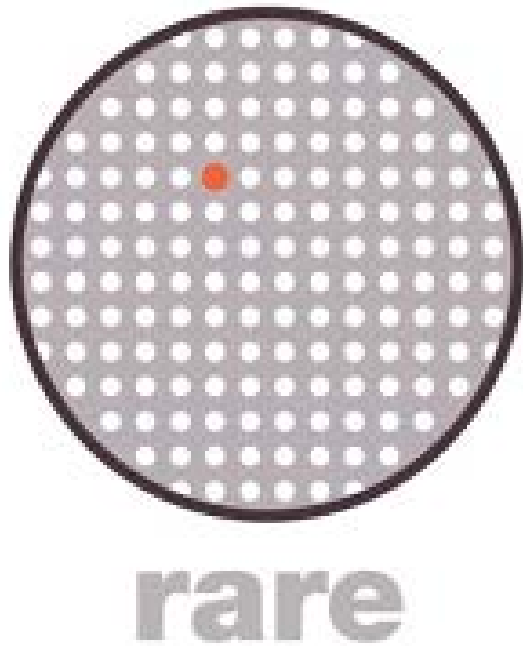
Length of Time in Emergency Shelter and Transitional Housing (Days)



ONE
TIME

Percent Returning after Exiting to Permanent Housing

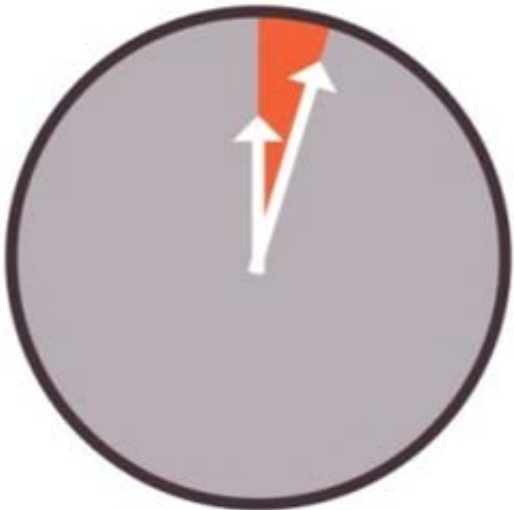




Working together with community advocates, providers and partners we are aligning our efforts towards:

- Prevention
- Affordable housing
- Reducing the cycle of criminal justice involvement and homelessness





brief



**one-
time**

For too many, a temporary crisis spirals into homelessness. Shortening the length of time families and individuals are homeless is key to reducing trauma.

We are:

- Individualizing our approach to providing services we can address the immediate crisis quickly and flexibly.
- Recommitting to housing first, to get people into housing and then address health and wellbeing





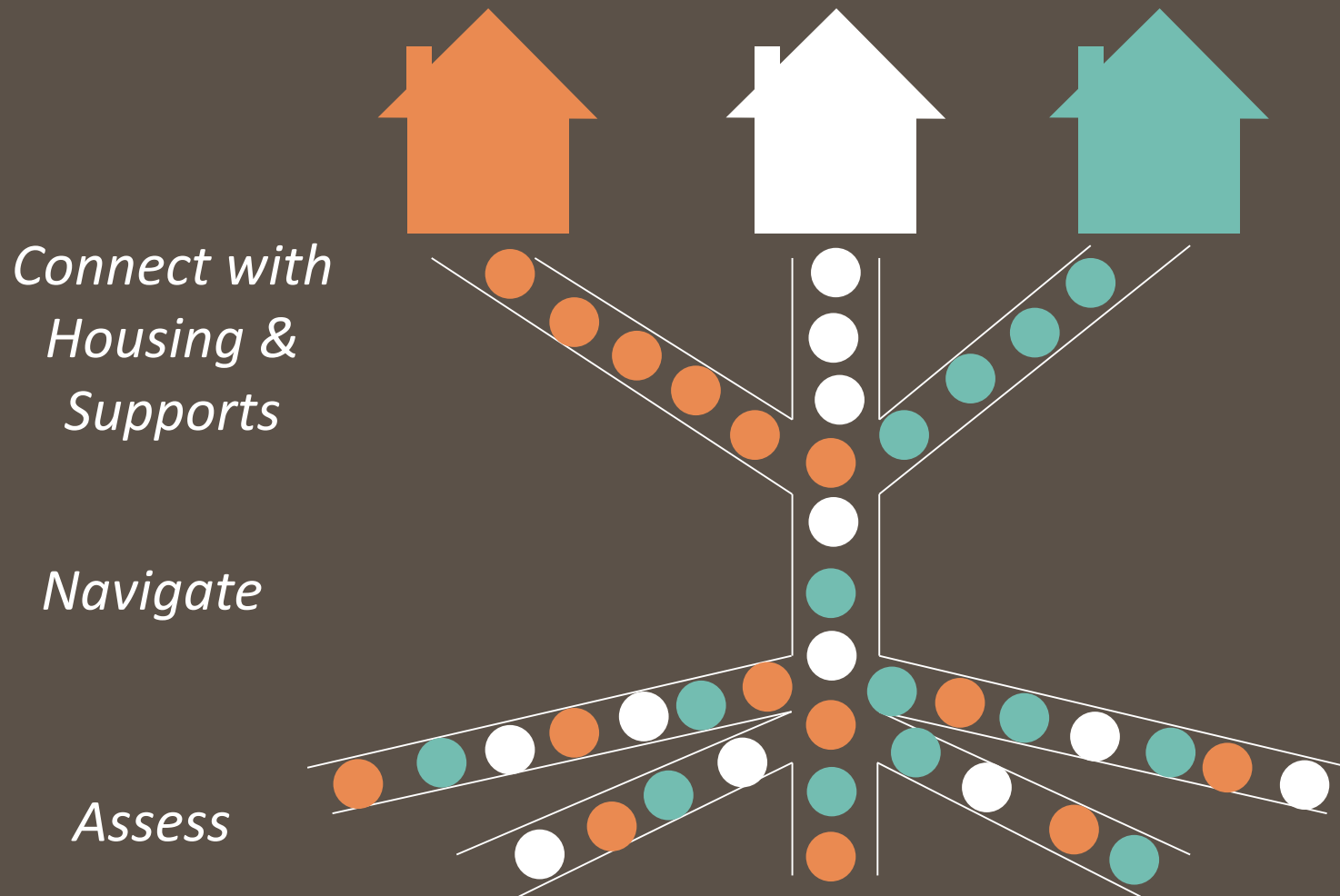
A Community to



End Homelessness



Coordinated Entry



SWAP

*System-Wide Analytics and Projection (SWAP)
is a suite of tools designed to assist
communities in creating a detailed vision of
homelessness system changes that will have
the greatest impact on reducing homelessness.*



Diversion

Diversion Works

Building Changes preliminary analysis
King County Diversion Pilot (as of June 2015)

MORE FAMILIES AVOID HOMELESSNESS ...

229

Number of families receiving diversion services
who successfully secured stable housing

... AND AT LESS COST

\$1,259

Estimate of financial assistance provided
per family in diversion program

\$10,067*

Average cost per exit for housing a family
with children in a shelter

(*National Alliance to End Homelessness estimate, 2012)

*Early engagement
quickly moves families
from the street to
housing, avoids costly
interventions, and frees
our limited shelter
resources for those who
have no other option.*

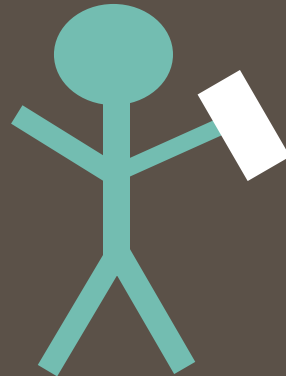


Rapid Re-housing

Rapid re-housing is a cost-effective strategy to help people successfully exit homelessness and maintain permanent housing by integrating three components:



**Housing
Services**



**Case
Management**



**Employment
Assistance**



Supportive Housing

SUCCESSFUL: Supportive Housing improves housing stability, employment, mental and physical health, and school attendance; and reduces active substance use. People in supportive housing live more stable and productive lives.

COST-EFFECTIVE: Supportive housing costs essentially the same amount as keeping people homeless and stuck in the revolving door of high-cost crisis care and emergency housing.

BENEFICIAL: Supportive housing helps build strong, healthy communities by improving the safety of neighborhoods, beautifying city blocks with new or rehabilitated properties, and increasing or stabilizing property values over time.





allhomekc.org



Mark Putnam

Director

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King County

Metropolitan King County Council Health, Housing and Human Services Committee

STAFF REPORT

Agenda Item:	11	Name:	Katherine Cortes
Proposed No.:	2016-0283	Date:	June 7, 2016

SUBJECT

Proposed Ordinance 2016-0283 would identify the composition and duties of the advisory body for the portion of the Best Starts for Kids levy related to the Communities of Opportunity initiative.

SUMMARY

Ordinance 18088¹ approved placing before King County voters a ballot measure authorizing a six-year property tax levy to support Best Starts for Kids (BSK), a prevention-oriented regional plan to support the healthy development of children and youth, families and communities across the county. The measure was approved by King County voters on November 3, 2015. Ordinance 18088 identified the Communities of Opportunity (COO) Interim Governance Group (IGG) as the advisory body for BSK levy proceeds set aside for the COO initiative, and directed the executive to transmit a plan relating to the COO IGG and a proposed ordinance that identifies the composition and duties of the IGG with respect to the COO portion of the BSK levy proceeds.²

Ordinance 18220³ identified the composition and duties of the IGG with respect to BSK levy proceeds, as required by Ordinance 18088, and directed that the IGG “shall serve as the advisory board for the communities of opportunity elements of the best starts for kids levy as set forth in Ordinance 18088 until a successor group is established by ordinance.” It further required the Executive to transmit motions (by February 15, 2016) confirming the appointments of two community representatives⁴ as well as an ordinance (by June 1, 2016) on the composition and duties of a successor to the COO IGG.

Proposed Ordinance 2016-0283 would identify and put into King County Code the composition and duties of a COO-Best Starts for Kids Levy Advisory Board to succeed

¹ Adopted July 20, 2015

² Ordinance 18088 also requires the establishment of an oversight and advisory body for the remainder of BSK levy proceeds. Pursuant to this requirement, Ordinance 18217 (adopted January 11, 2016) created the Children and Youth Advisory Board.

³ Adopted January 19, 2016

⁴ Motions 14581 (confirming the appointment of Ubox Gardheere) and 14580 (confirming the appointment of John Page) were adopted March 7, 2016.

the IGG. Staff and legal analysis are ongoing as to whether Proposed Ordinance 2016-0283 conforms with the provisions of Ordinance 18220.

BACKGROUND

Communities of Opportunity

Communities of Opportunity (COO) is a place-based initiative which began as an early strategy of the King County Health and Human Services Transformation Plan (HHS Transformation Plan),⁵ and has operated since March 2014 as a partnership with The Seattle Foundation.

Communities of Opportunity was one of two early "go-first" strategies of the HHS Transformation Plan, established as a 3-year effort with staffing support from Public Health – Seattle and King County and the Department of Community and Human Services, and \$500,000 appropriated in a "catalyst fund"⁶ to support related work outside of King County government.

On a timeline parallel to the development of the HHS Transformation Plan, The Seattle Foundation's Center for Community Partnerships was crafting a neighborhood partnership initiative to address economic and racial equity. Rather than proceed with separate parallel efforts, The Seattle Foundation and King County joined forces to launch Communities of Opportunity.

COO developed as a communities-focused strategy to support King County neighborhoods in developing capacity and solutions to improve the community features that shape the health and well-being of their residents and the vibrancy of these places, such as housing, physical environment, adequate employment, and access to services. Proposed Ordinance 2016-0281, approving the Best Starts for Kids Implementation Plan, and its attached plan include a plan for the portion of the Communities of Opportunity initiative that would be funded by Best Starts for Kids levy proceeds. Analysis of that legislation is ongoing and adoption of that plan, along with any adopted amendments, would likely reflect an evolution of the initial strategy—at least as it concerns BSK levy proceeds.

The Seattle Foundation currently serves as a joint administrator with King County of the Communities of Opportunity initiative. The relationship between King County and The Seattle Foundation as founders of Communities of Opportunity is formalized through a memorandum of understanding signed by the 14 members of the IGG prior to the passage of Ordinance 18220 and a contract between King County and The Seattle Foundation.

Communities of Opportunity Governance and Best Starts for Kids

On November 3, 2015, King County voters approved a six-year property tax levy to fund Best Starts for Kids (BSK), a prevention-oriented regional plan that is aimed at supporting the healthy development of children and youth, families and communities across the county. (Placement of the BSK ballot measure before King County voters was directed and authorized by Ordinance 18088, enacted in July 2015.) The property

⁵ Ordinance 13943 (accepted by the Council in July 2013)

⁶ Ordinance 17829

tax will be levied at a rate of \$0.14 per \$1,000 of assessed valuation in 2016, with an increase of up to three percent for each of the five subsequent years of the levy—2017 through 2021. Executive staff project that the BSK levy will generate a total of approximately \$400 million in revenues over the six-year levy period.

Executive staff further estimate that the Communities of Opportunity (COO) portion (10 percent) of the Best Starts for Kids levy proceeds (less initial collections for a youth and family homelessness prevention initiative and amounts for costs attributable to the election) will total almost \$37 million over the life of the levy.⁷

Ordinance 18088 identified the Communities of Opportunity (COO) Interim Governance Group (IGG) as the advisory body for the portion of BSK levy proceeds set aside for the COO initiative, and directed the executive to transmit a plan relating to the COO IGG and a proposed ordinance that identifies the composition and duties of the IGG with respect to the COO portion of the BSK levy proceeds.⁸

Ordinance 18088 defines the "communities of opportunity interim governance group" as meaning "the group and any successor group charged with advising on strategic direction and operation for communities of opportunity. The communities of opportunity interim governance group shall include one appointee of the executive and one appointee of the council, respectively, who shall be confirmed by ordinance." Ordinance 18088 also provides that if the levy is approved by the voters, the COO IGG "will be reconstituted in accordance with Section 7.B." of the levy ordinance.

Section 7.B. of Ordinance 18088 states:

"The communities of opportunity interim governance group shall serve as the advisory board for levy proceeds described in section 5.C.3. of this ordinance. The executive shall transmit to the council by December 1, 2015 a plan relating to the communities of opportunity interim governance group and a proposed ordinance that identifies the composition and duties of the interim governance group with respect to the levy proceeds described in section 5.C.3. of this ordinance."

Prior to and immediately after voters approved the property-tax levy to fund Best Starts for Kids, the COO IGG served as the advisory body responsible for guiding investments related to COO. It was tasked with advising on late 2014 and early 2015 activities while simultaneously facilitating the establishment of the ongoing Governance Group structure.

Pursuant to Ordinance 18088, the Executive transmitted an ordinance identifying the composition and duties of the IGG with respect to BSK levy proceeds. Council revised and adopted this as Ordinance 18220.⁹ The adopted ordinance required the Executive to transmit motions (by February 15, 2016) confirming the appointments of two

⁷ Staff analysis on these figures is ongoing.

⁸ Ordinance 18088 also requires the establishment of an oversight and advisory body for the remainder of BSK levy proceeds. Pursuant to this requirement, Ordinance 18217 (adopted January 11, 2016) created the Children and Youth Advisory Board.

⁹ Adopted January 19, 2016

community representatives¹⁰ as well as an ordinance (by June 1, 2016) on the composition and duties of a successor to the COO IGG.

Ordinance 18220, enacted in January 2016, stood up the COO IGG as the advisory body for the COO portion of Best Starts for Kids programming charged with: 1) collaborating with the King County Executive in the development of the BSK implementation plan portions related to Communities of Opportunity (due June 1) and 2) making recommendations to the King County Executive concerning expenditures of BSK levy proceeds to plan, provide and administer communities of opportunities after the adoption by ordinance of the referenced implementation plan. The ordinance further directed that the IGG “shall serve as the advisory board for the communities of opportunity elements of the best starts for kids levy as set forth in Ordinance 18088 until a successor group is established by ordinance.”

Ordinance 18220 established Betsy Jones as the representative of the King County executive and added Scarlett Aldebot-Green as the representative of the King County Council on the IGG. Further, this ordinance established two positions for community representatives on the IGG, directing that these appointees shall:

- Reflect the demographic characteristics of the communities that would qualify for funding under either the funding guidelines established for the pre-levy communities of opportunity initiative or the funding guidelines established in the implementation plan for the best starts for kids levy required under Ordinance 18088 once the plan is approved by ordinance, or both;
- Be grassroots organizers or activists with relevant organizing and advocacy experience necessary to effectively address the health, racial and economic inequities facing persons residing in the communities of opportunities neighborhoods; or
- Live in or have worked in a community the characteristics of which would qualify it for COO funding.

Motions confirming the appointment of the two community appointees (Ubox Gardheere¹¹ and John Page¹²) were adopted March 7, 2016.

Present Membership of the COO IGG

1. Scarlett Aldebot-Green, King County Council representative
2. Michael Brown, The Seattle Foundation (TSF)
3. Deanna Dawson, Sound Cities Association
4. David Fleming, PATH
5. Hilary Franz, Futurewise
6. Ubox Gardheere, community appointee
7. Patty Hayes, Public Health-Seattle & King County (PHSKC)
8. Betsy Jones, Executive’s Office, King County

¹⁰ Motions 14581 (confirming the appointment of Ubox Gardheere) and 14580 (confirming the appointment of John Page) were adopted March 7, 2016.

¹¹ Motion 14581

¹² Motion 14580

9. Paola Maranan, The Children's Alliance
10. Gordon McHenry, Jr, Solid Ground
11. Jeff Natter, Pacific Hospital PDA
12. John Page, community appointee
13. Adrienne Quinn, King County Department of Community and Human Services (DCHS)
14. Michael Woo, community representative
15. Tony To, HomeSight (Rainier Valley site representative)
16. Adam Taylor, Global to Local (SeaTac/Tukwila site representative)
17. Sili Savusa, White Center Community Development Association (White Center site representative)

Section 1.G of Ordinance 18220 establishes that the proposed ordinance on the composition and duties of a successor to the IGG shall do the following:

1. *Identify the structure of the communities of opportunity interim governance group including size, terms of service, qualification requirements and voting system, including the rules by which a potential conflict of interest will be addressed for communities of opportunity interim governance group members who represent sites or communities when a vote related to those sites or communities is before the communities of opportunity interim governance group; and*
2. *Include positions for one council appointee and one executive appointee, both of whom must be confirmed by ordinance;*
3. *Require that appointments to the successor group seek to include community appointees equal in number to at least two persons, or twenty percent of the total number of members, whichever is greater; and*
4. *Require that the successor group membership reflects the diversity in King County and that the successor group recognizes that strategies may vary for different populations and in different locations of the county where there are inequitable health and well-being outcomes.*

ANALYSIS

Proposed Ordinance 2016-0283 would identify and put into King County Code the composition and duties of a COO-Best Starts for Kids Levy Advisory Board to succeed the IGG. Staff and legal analysis are ongoing as to whether Proposed Ordinance 2016-0283 conforms with the provision of Ordinance 18220. Potential issues for Council consideration, some requiring additional staff analysis, are outlined below.

1) Codification

The decision of whether to codify any ordinance is vested in the Clerk of the Council under K.C.C. 1.03.020. She is required to codify any ordinance of a "general or permanent nature." The duties of the COO-Best Starts for Kids Levy Advisory Board are related to the six-year BSK levy. Since after all levy proceeds are expended the function of the advisory board would cease, the ordinance is not of a general or permanent nature and would not be codified. Prior to passage, Ordinance 18220 (as PO 2015-

0521) was amended in committee to eliminate codification language proposed by the Executive in the original transmittal, for the same reason.

2) Size

PO 2016-0283, Section 1.A.1 states that the Advisory Board will consist of fourteen to eighteen members, as determined by the board. The Council may wish to consider whether this is the appropriate size, and whether allowing the specific number to be dictated by the body itself meets the policy goals of Council.

3) Voting System

PO 2016-0283 Section 1.A.4 prescribes that “the board shall use a formal consensus process for making decisions.” Staff is reviewing whether a formal consensus process meets the definition of the “voting system” required by Ordinance 18220.

4) Conflict of interest policy

PO 2016-0283 Section 1.A.5 states “The board shall have a conflict of interest policy, which requires members to declare a conflict in advance of a board decision in which the members, their partners or spouses have a potential financial, fiduciary or employment conflict of interest, and to recuse themselves from that decision.” Staff is reviewing whether this provision satisfies the requirement in Ordinance 18220 for a policy addressing conflicts of interest for “members who represent sites or communities when a vote related to those sites or communities is before the communities of opportunity interim governance group.”

5) Community appointees

Ordinance 18220 requires that the successor group seek to include the greater of two persons or twenty percent of the total number of members who are “community appointees.” While the characteristics of the appointees on the successor group are not prescribed, Ordinance 18220 creates two positions for community appointees on the IGG and requires that these members:

- Reflect the demographic characteristics of the communities that would qualify for funding under either the funding guidelines established for the pre-levy communities of opportunity initiative or the funding guidelines established in the implementation plan for the best starts for kids levy required under Ordinance 18088 once the plan is approved by ordinance, or both;
- Be grassroots organizers or activists with relevant organizing and advocacy experience necessary to effectively address the health, racial and economic inequities facing persons residing in the communities of opportunities neighborhoods; or
- Live in or have worked in a community the characteristics of which would qualify it for COO funding.

PO 2016-0283 Section 1.b.4 responds to this provision by requiring that “At least twenty percent of the advisory board members, or three, whichever is greater, shall be community members who reflect demographic characteristics of the communities that qualify for funding in accordance with the communities of opportunity funding guidelines, and who are grassroots organizers, and who live in or have worked in such

communities.” Staff is reviewing whether the directive to include community “appointees” is satisfied by positions for community “members” selected by the IGG and subsequently by the board itself, or whether the term “appointees” prescribes an Executive appointment and Council confirmation process.

As context, Ordinance 18220 did not explicitly require Council confirmation of the community appointees on the IGG, but the Executive did transmit appointments for these members, who were confirmed by Council in Motions 14580 and 14581. (There is also language in Ordinance 18088 and Ordinance 18220 around Council and Executive appointees that explicitly specifies that they must be confirmed by ordinance.)

As a matter of policy, there is a material difference in the characteristics required of the community members in PO 2016-0283 versus the community appointees on the IGG (defined in Ordinance 18220) – Ordinance 18220 links the requirements bulleted above with “or” while PO 2016-0283 links them with “and,” i.e. requiring community members on the Advisory Board to have all three bulleted characteristics.

6) Diversity of Membership

Ordinance 18220, Section 1.G.3 requires that the ordinance transmitted by the Executive “Require that the successor group membership reflects the diversity in King County and that the successor group recognizes that strategies may vary for different populations and in different locations of the county where there are inequitable health and well-being outcomes.”

These words are not reflected in PO 2016-0283, though the proposed ordinance does direct that “Members will reflect a range of backgrounds, including living in or working in affected communities, working in a community-based organization, nonprofit agency, intermediary organization, business or institution, and shall have experience in the relevant subject matter areas.” Staff is analyzing whether this and other provisions in the proposed ordinance satisfy the requirement for reflecting the diversity in King County.

7) Recognition of Variant Strategies

Staff is further analyzing whether any provisions in PO 2016-0283 require that the successor group recognize that strategies may vary for different populations and locations in the County, as required by Ordinance 18220, Section 1.G.3.

8) Sequence of adoption versus PO 2016-0281 (BSK General Implementation Plan)

PO 2016-0283 Section 1.A.2 states in part that members “must be committed to the communities of opportunity best starts for kids levy implementation plan, which will be adopted by the council by ordinance, as evidenced through a written agreement of the commitment to serve on the board” (emphasis added).

PO 2016-0283 Section 1.B states in part that “The duties of the board are to review and make advisory recommendations to the executive and county council concerning the use of levy proceeds for the communities of opportunity element of the best starts for kids levy, consistent with the council adopted communities of opportunity section of the best starts for kids levy implementation plan” (emphasis added).

Staff is analyzing whether the language in these two provisions sets up conflicting direction as to whether the BSK implementation plan must be adopted prior to or after PO 2016-0283.

9) Recommendations to the Executive and County Council

Related to the statement excerpted from PO 2016-0283 Section 1.B in item #8 above, staff is reviewing whether making advisory recommendations to the Council prescribes a different or additional process than making recommendations to the Executive only. As context, Ordinance 18220 defined the duties of the IGG as including “to make recommendations to the Executive” concerning the expenditure of the COO allocation of best starts for kids levy proceeds.

10) Selection of Advisory Board members

The transmittal letter for PO 2016-0283 describes a process by which the final roster of members for the proposed COO-Best Starts for Kids Levy Advisory Board will be selected, as follows:

The IGG will establish a subcommittee that will serve as a transition committee to be formed in the fall of 2016. The transition committee will solicit information from current IGG members regarding their interest in ending their term of service with the IGG, or in continuing their service on the COO-BSK Advisory Board/COO Governance Group. In addition, the transition committee will collect recommendations from the IGG for potential new members of the COO Governance Group and will also review Letter(s) of Interest to Serve on the governance group received via the King County website, if any such letters are received. Lastly, the transition committee will use a COO Results and Sectors Matrix Tool to aid them in making recommendations for a final roster of advisory board members that complies with this ordinance and is a robust cross-sector board reflecting the wealth of diversity in King County. The IGG will make a final decision regarding the membership of the COO-BSK Advisory Board/COO Governance Group by the end of 2016.

The Council may wish to consider whether this declaration of intent and specifics of that process will meet the Council’s goals, including with respect to the sufficiency of access to the board by new members, or whether this process or any specific membership characteristics should be further defined within proposed ordinance 2016-0283.

11) Additional provisions

The Council may also wish to consider whether the proposed ordinance sufficiently defines the structure and duties of the successor group with respect to such provisions as the frequency of meetings, the way meetings are noticed, and potential policies around member attendance and compensation.

Staff analysis on precedent for defining such provisions is ongoing.

ATTACHMENTS

1. Proposed Ordinance 2016-0283
2. Transmittal Letter
3. Fiscal Note

INVITED

1. Adrienne Quinn, Director, Department of Community and Human Services (DCHS)
2. Patty Hayes, Director, Public Health – Seattle & King County
3. Michelle Allison, Director of Council Relations, King County Executive's Office
4. Betsy Jones, Health and Human Potential Policy Advisor, DCHS
5. Cheryl Markham, Strategic Policy Advisor, DCHS

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Signature Report

June 6, 2016

Ordinance

1200 King County Courthouse
516 Third Avenue
Seattle, WA 98104

Proposed No. 2016-0283.1

Sponsors Kohl-Welles and Dembowski

1 AN ORDINANCE relating to the structure and duties of a
2 successor to the communities of opportunity interim
3 governance group with respect to the communities of
4 opportunity portion of the best starts for kids levy proceeds;
5 and adding a new section to K.C.C. chapter 2A.300.

6 STATEMENT OF FACTS:

- 7 1. Communities of Opportunity ("COO"), which was launched by the
8 Seattle Foundation and King County in March 2014, is designed to
9 improve equity in health and well-being outcomes in the places in King
10 County that have the most to gain; these are places in King County that
11 fall within the bottom thirty-five percent for health and well-being
12 outcomes.
- 13 2. COO works in partnership with community leaders, community
14 residents and coalition or partnerships, community-based organizations,
15 intermediary organizations and other funders and partners that agree to
16 work in a collective impact model, in which cross-sector partners share a
17 common vision for change, as well as a shared agenda for measuring
18 results, holding each other accountable, engaging in open communication,
19 and providing adequate backbone support for the work. A COO interim

20 governance group, made up of King County and Seattle Foundation
21 appointees and a cross-section of COO partners has been in place since
22 October 2014.

23 3. Under Ordinance 18088, the COO interim governance group shall
24 serve as the advisory board for the COO elements of the best starts for
25 kids levy and consistent with Ordinance 18220 serves until a successor
26 group is established by ordinance. Accordingly, the county executive has
27 been working with founding partner, the Seattle Foundation and the COO
28 interim governance group to plan for the transition to a permanent
29 governance group that will also serve as the COO-best starts for kids
30 advisory board for the best starts for kids levy COO elements by the end
31 of year 2016. The same parties have also been working on the
32 development of an implementation plan for the expenditure of the funding
33 associated with the COO element of the best starts for kids levy, for
34 adoption by council.

35 4. The COO interim governance group members, as prescribed by
36 Ordinance 18220, have met at least eleven times over the first five months
37 of 2016 to identify a proposed structure of the ongoing COO governance
38 group, which group will also serve as the ongoing COO-best starts for kids
39 levy advisory board. The COO interim governance group developed
40 policies for the COO-best starts for kids levy advisory board that include
41 the structural elements requested by council in Ordinance 18220, Section
42 1.G.

43 BE IT ORDAINED BY THE COUNCIL OF KING COUNTY:

44 NEW SECTION. SECTION 1. There is hereby added to K.C.C. chapter 2A.300

45 a new section to read as follows:

46 A. The communities of opportunity-best starts for kids levy advisory board shall
47 be structured as follows:

48 1. The board shall consist of a minimum of fourteen members and a maximum
49 of eighteen members, as determined by the board;

50 2.a. Members of the board shall possess specific context or content experience
51 related to improving health and well-being outcomes in communities with the greatest
52 need for improvement, and must be committed to the communities of opportunity best
53 starts for kids levy implementation plan, which will be adopted by the council by
54 ordinance, as evidenced through a written agreement of the commitment to serve on the
55 board. Members will reflect a range of backgrounds, including living in or working in
56 affected communities, working in a community-based organization, nonprofit agency,
57 intermediary organization, business or institution, and shall have experience in the
58 relevant subject matter areas of housing, health, social and community connection or
59 economic prosperity.

60 b. The board membership is constituted as follows:

61 (1) Two members shall be appointed by the Seattle Foundation;

62 (2) One member shall be appointed by the county executive, and confirmed
63 by the council;

64 (3) One member shall be appointed by the county council;

65 (4) At least twenty percent of the advisory board members, or three,
66 whichever is greater, shall be community members who reflect demographic
67 characteristics of the communities that qualify for funding in accordance with
68 communities of opportunity funding guidelines, and who are grassroots organizers or
69 activists in such communities, and who live in or have worked in such communities;

70 (5) At least two members of the board will be representatives from
71 communities receiving place-based funding from communities of opportunity; and

72 (6) The remaining board members will be selected by the board;

73 3. The two members appointed by the county and the two members appointed
74 by the Seattle Foundation do not have term limits and shall serve until new appointments
75 are made. The place-based community site representatives on the board have terms of at
76 least one year and no more than three years; the participating place-based site board
77 members will determine their rotation on the board. All other board members shall have
78 three-year terms that may only be renewed one time;

79 4. The board shall use a formal consensus process for making decisions
80 concerning recommendations for the communities of opportunity best starts for kids levy
81 proceeds. Meeting notes shall reflect these decisions; and

82 5. The board shall have conflict of interest policy, which requires members to
83 declare a conflict in advance of a board decision in which the members, their partners or
84 spouses have a potential financial, fiduciary or employment conflict of interest, and to
85 recuse themselves from that decision.

86 B. The duties of the board are to review and make advisory recommendations to
87 the executive and county council concerning the use of levy proceeds for the

88 communities of opportunity element of the best starts for kids levy, consistent with the
89 council adopted communities of opportunity section of the best starts for kids levy
90 implementation plan.

91 C. Administrative support will be provided to the board by the communities of
92 opportunity staff team in the department of community and human services and public
93 health - Seattle and King County.

94 D. Meetings of the board will be posted on the county communities of
95 opportunity website and will be open to the public to listen and observe the meetings.

96 SECTION 2. A. The member of the communities of opportunity-best starts for
97 kids levy advisory board appointed to represent the executive is Betsy Jones, who is
98 hereby confirmed.

99 B. The member of the communities of opportunity best starts for kids levy

100 advisory board appointed to represent the county council is _____, who
101 is hereby confirmed.
102

KING COUNTY COUNCIL
KING COUNTY, WASHINGTON

J. Joseph McDermott, Chair

ATTEST:

Anne Noris, Clerk of the Council

APPROVED this ____ day of _____, ____.

Dow Constantine, County Executive

Attachments: None

June 1, 2016

The Honorable Joe McDermott
Chair, King County Council
Room 1200
C O U R T H O U S E

Dear Councilmember McDermott:

I am pleased to transmit an ordinance approving the structure and duties of a successor to the Communities of Opportunity (COO) Interim Governance Group (IGG), which will serve as the COO Best Starts for Kids (BSK) Levy Advisory Board. This ordinance will also confirm the Executive and Metropolitan King County Council appointments to the advisory board.

As you are aware, the COO initiative was launched in early 2014 after a period of planning between founding partners, the Seattle Foundation and King County Departments of Community and Human Services and Public Health. For King County, COO was a “go first” strategy of our Health and Human Services Transformation Plan, a significant body of work under the County’s Health and Human Potential goal of the Strategic Plan to provide opportunities for all individuals to realize their full potential. For the Seattle Foundation, COO was aligned with the launch of their new Center for Community Partnerships. The Seattle Foundation has been, and will continue to be, a significant funder and partner in COO.

The founding partners have worked with the COO IGG members over the past five months to develop a set of policies and proposed structure for the successor governance group to the IGG, which will also serve as the COO BSK Levy Advisory Group. The founding partners have also worked with the IGG on the development of the COO section of the Best Starts for Kids Levy Implementation Plan, transmitted simultaneously with this ordinance.

The structure and process outlined in this ordinance responds directly to the request in Ordinance 18220 for the transmittal of an ordinance that identifies the structure of the successor advisory board, including the size, terms of service, qualifications, voting system and rules regarding conflict of interest. The remaining content of this ordinance addresses the following requirements of Ordinance 18220: that 1) the successor advisory board include community appointees as defined in Ordinance 18220; 2) the advisory board shall reflect the diversity in King County and the recognition that strategies may vary for different

populations and locations of the County; and 3) the ordinance shall include the Council and Executive appointees, to be confirmed by Council.

The IGG will establish a subcommittee that will serve as a transition committee to be formed in the fall of 2016. The transition committee will solicit information from current IGG members regarding their interest in ending their term of service with the IGG, or in continuing their service on the COO-BSK Advisory Board/COO Governance Group. In addition, the transition committee will collect recommendations from the IGG for potential new members of the COO Governance Group and will also review Letter(s) of Interest to Serve on the governance group received via the King County website, if any such letters are received. Lastly, the transition committee will use a COO Results and Sectors Matrix Tool to aid them in making recommendations for a final roster of advisory board members that complies with this ordinance and is a robust cross-sector board reflecting the wealth of diversity in King County. The IGG will make a final decision regarding the membership of the COO-BSK Advisory Board/COO Governance Group by the end of 2016.

The structure and requirements outlined in this ordinance for the COO governance group supports the King County Strategic Plan goal of public engagement and furthers the work of the King County Equity and Social Justice Initiative, by requiring group membership that reflects the diversity in King County.

On behalf of the IGG, and our funder and community partners who have invested significant resources, time and energy in Communities of Opportunity, I would like to thank you for your support of the structure and processes outlined in this ordinance.

If you would like any additional information, please contact Adrienne Quinn, Department of Community and Human Services Director, at 206-263-9100.

Sincerely,

Dow Constantine
King County Executive

Enclosures

cc: King County Councilmembers
 ATTN: Carolyn Busch, Chief of Staff
 Anne Noris, Clerk of the Council
Carrie S. Cihak, Chief of Policy Development, King County Executive Office
Dwight Dively, Director, Office of Performance, Strategy and Budget
Adrienne Quinn, Director, Department of Community and Human Services (DCHS)
Cheryl Markham, Strategic Policy Advisor, DCHS

ATTACHMENT 3